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AN EXILE IN MY OWN COUNTRY:
THE CONFINEMENT OF LEPROSY PATIENTS
AT THE UNITED STATES NATIONAL LEPROSARIUM

JOHN PARASCANDOLA

Public Health Service Historian
U. S. Department of Health and Human Services,
National Library of Medicine, Bethesda, Md, USA

SUMMARY

Leprosy is a disease which has long been stigmatized, and persons afflicted with it have frequently been segregated from the rest of society. This paper focuses on the evolution of policies concerning the confinement of patients at the national leprosarium operated by the United States Public Health Service (PHS) at Carville, Louisiana. After a brief review of the origins of the Louisiana Leper Home, which eventually became the national leprosarium, the paper traces changing attitudes and policies at Carville from 1921, when the PHS took control of the facility, to the 1950s.

Then I noticed the high metal cyclone fence with the three strands of barbed wire running along the top. I first saw the uniformed guards at the gate - and I realized the dreadful moment I had been fighting against for nearly ten years had come at last. I had arrived at U.S. Marine Hospital No. 66, Carville, Louisiana, then, as now, the only institution in the continental United States devoted exclusively to the treatment of leprosy. At ten o'clock on that Sunday morning, March 1, 1931, I became an exile in my own country.¹

In these words, Stanley Stein, in an autobiography first published in 1963, recalled his arrival at the national leprosarium

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operated by the United States Public Health Service. Stein had been born Sidney Maurice Levyson in Gonzales, Texas on June 10, 1899, but followed the typical practice of adopting an alias upon entering the leprosy hospital in order to protect his family from the disgrace that was unfortunately associated with the disease. He was 21 years old and working as a pharmacist when he was diagnosed with leprosy (today known as Hansen's disease), a verdict that he viewed as a pronouncement of doom. *Leprosy was not just a disease*, Stein asserted, it was a stigma, a disgrace, a visitation from on high, a punishment for some dreadful sin.²

Stein's reaction to the disease and to his admission into the hospital at Carville was not atypical. Nineteen-year old Betty Carter (another Carville alias) of New Orleans was horrified on learning that she had the disease, which called to her mind visions of *draped forms and warning bells and perpetual banishment*. When she left home to enter the national leprosarium in January of 1928, she thought of it as *the place of isolation*.³

Given the stigma of the disease and the ineffectiveness of treatment for it before the 1940s, many patients who entered the leprosy hospital in this era did indeed find themselves confined to the institution for a long stay. Betty Carter Martin and her husband Harry Martin (who had arrived at Carville at about the same time as his future wife) were not discharged from the hospital until 1947 (though they escaped for a few years in the 1930s before voluntarily returning). Stanley Stein never did leave the Carville facility, but died there in 1967. This paper will examine, within the limits of available space, the evolution of Public Health Service policies for leprosy patients at Carville, particularly those involving the segregation of patients from the society outside the hospital.⁴

Origins of the Leprosy Hospital at Carville

On November 30, 1894, five men and two women suffering from leprosy arrived by barge at Indian Camp, Iberville Parish in Louisiana as the first patients of the Louisiana Leper Home. Indian Camp was an abandoned sugar plantation situated on the banks of the Mississippi River between Baton Rouge and

New Orleans. On the recommendation of the Orleans Parish Medical Society, the state legislature of Louisiana had passed an act that set up the *Board of Control for the Louisiana Leper Home* in September of 1894, with Dr. Isadore Dyer as its President.

The only housing then available to lepers in New Orleans had been called a *pest-house* by Dyer, and he and the Board searched for a site to establish a more humane facility. Because of community opposition, Dyer was unable to find a site in New Orleans, and he finally leased Indian Camp under the pretext that it would be used as an ostrich farm. The plantation was located near the hamlet of Carville, and the leprosarium came to be referred to as Carville.

Dyer soon arranged a contract with the Daughters of Charity of St. Vincent De Paul, who had served at the New Orleans Charity Hospital for sixty years, to provide the new leprosarium with nursing services and domestic management. In 1896, the first four sisters arrived to take up their duties at Carville, beginning a tradition that continues up to the present.⁵

Carville remained a state institution until 1921, when it was taken over by the Federal Government. For years Dyer promoted the concept of Carville as a center for leprosy research and treatment, but the state seemed content to operate it essentially as an asylum. Finally in 1917, Congress authorized the Public Health Service to establish a national leprosarium, with Dyer, by then Dean of the Tulane University Medical School, testifying on behalf of the bill. After several potential sites for such a hospital were abandoned due to resistance from local communities, it was decided to purchase the Louisiana Leper Home, which the state was quite willing to sell. In 1921, Carville became U. S. Marine Hospital Number 66 of the Public Health Service (PHS).

As soon as the PHS took over Carville, it assigned to the hospital its first full-time, resident physicians and medical support staff, in addition to the nurses already there. Dr. Oswald Denney, who had served as director of the leper colony in the Philippines, was appointed as the first Chief Medical Officer. In 1923, Congress appropriated \$645,000 to modernize and expand the hospital.⁶

Confinement of Leprosy Victims

The 1917 legislation that authorized the establishment of a national leprosarium stipulated that the facility should admit any person afflicted with the disease who presented himself or herself for *care, detention, and treatment*. It also stated that the leprosarium should receive those who *may be apprehended under authority of the United States quarantine acts, or any person afflicted with leprosy duly consigned to said home by the proper health authorities of any State, Territory, or the District of Columbia*. Further, it authorized the PHS Surgeon General, at the request of any health authority, *to send for any person within the jurisdiction of such authority who is afflicted with leprosy and to convey that person to the appropriate hospital for detention and treatment*. The act also gave the Surgeon General the authority to make regulations for the apprehension, detention, treatment, and release of leprosy patients.⁷

The forced confinement of persons with leprosy was nothing new. From at least the time of the Old Testament, leprosy was branded as an abomination (although questions have been raised by some as to whether the skin disease described in the Bible was really leprosy). In the early Middle Ages, measures were taken in Europe to restrict the freedom of movement of lepers. They were expelled from the community and compelled to live in a hut or a leprosarium outside the confines of the community. It has been estimated that there were some 19,000 leper houses throughout Europe at the beginning of the 13th century. *Fear of all other disease taken together, wrote historian George Rosen, can hardly be compared to the terror created by leprosy.*⁸

After the Middle Ages, however, the incidence of leprosy declined dramatically in Europe. In the United States, the disease was never common, and does not appear to have been a matter of widespread public concern until late in the nineteenth century. In the 1880s, apprehension about the disease apparently began to increase in both Europe and North America. The discovery of the bacillus that causes leprosy by Gerhardt Hansen in Norway in the 1870s, which made the infectious nature of the disease all the more clear, probably contributed to rising fear of the disease. The outbreak of leprosy in Hawaii in the 1860s, and

especially the well-publicized news that Father Damien had contracted the disease there in the following decade, also helped to shape Western attitudes towards leprosy. Zachary Gussow has argued that racist views towards immigrant groups associated in Western minds with the disease, especially the Chinese, were also a factor in the increased concerns about leprosy.⁹

By 1889, the issue of whether or not the Federal government should create a facility for the segregation of lepers had been introduced into the U.S. Congress, although no action was taken at the time. In the late nineteenth century, however, leprosy was classified as a quarantinable disease under Federal regulations established by the PHS (known as the Marine Hospital Service at the time). The Service also listed leprosy as one of the *loathsome contagious diseases* that could exclude immigrants under 1891 Federal immigration legislation.¹⁰

In Louisiana, where there was a relatively high incidence of the disease, the state legislature mandated in 1892 that all persons with leprosy be confined in isolated institutions for the treatment of the disease. The law required the reporting of lepers and provided penalties for harboring them. It was this act which ultimately led to the establishment of the Louisiana Leper Home in Carville.¹¹

As previously mentioned, the 1917 act leading to the conversion of Carville into a Federal facility did provide the Surgeon General of the PHS with a certain authority to compel leprosy victims to come to or remain at Carville. In reality, however, there were significant limitations to the exercise of this authority. As Gussow has pointed out, the Surgeon General had no power to compel a state to send someone to Carville. A state health official had to initiate the request to the PHS, and states varied in their policies concerning confinement of leprosy patients. It appears that generally efforts were made to persuade persons with leprosy to enter Carville voluntarily, although it is likely that in many cases the advice of physicians and/or family members made them feel as if they had little choice. In theory, a person with leprosy crossing a state line could have been apprehended under Federal quarantine law and consigned to Carville, but the PHS did not have the resources to enforce such a policy.¹²

Similarly, in spite of some efforts to develop means of preventing patients from leaving the hospital without permission, it was apparently not that difficult for a determined patient to *abscond* from the facility. Harry and Betty Martin cut a hole in the barbed-wire fence one night and fled Carville. Nevertheless, even the presence of a barbed-wire fence and the fact that one had to *escape* to leave if not medically discharged must have given many the feeling that they were prisoners and not just patients. When a patient did leave Carville without permission, the PHS informed the health authorities of his or her state, who could forcibly return the individual to the leprosarium if he or she were captured. On being returned to Carville, the recalcitrant patient might be placed for a time under detention or even in the jail that existed on the hospital's premises. When the Martins returned to Carville voluntarily they were *punished* in this manner.¹³

To help *overcome the tendency to abscond from nostalgia or under extenuating circumstances*, the PHS began a policy of passes for home visits not long after taking over the operation of Carville. The policy *permitted a leper to visit his home under certain restrictions for a short period of time, the visit being pre-arranged with the consent of the appropriate state and city health officers and being under the immediate supervision of an attendant*. The number of patients who were permitted to leave under those circumstances was apparently very small. Even those who were allowed to go could not always afford the cost, for the patient was responsible for covering his or her own travel expenses and those of the accompanying medical officer or other attendant. These expenses could be considerable as the patient generally had to travel in a Pullman compartment on a train or hire a private automobile.¹⁴

The Sulfones Provide Hope

Until the 1940s, patients suffering from leprosy had little hope for significant and sustained improvement in their medical condition. The standard treatment for the disease was *chaulmoogra oil* and its derivatives. Although many physicians were convinced that this drug was effective against leprosy, others were extremely skeptical about the claims that were made for it.

George McCoy, who had served for many years as director of the National Institute (later Institutes) of Health, published an attack on *chaulmoogra oil* in 1942. McCoy noted that many experienced students of the disease expressed serious doubts about the value of the oil in treating leprosy, especially when discussing the subject in private.¹⁵

Whether or not one believed that *chaulmoogra oil* was of any value in treating leprosy, it would have been difficult to argue that it was an ideal therapeutic agent. Stanley Stein took the oil for many years without significant improvement, although he believed that it had once cleared up a cluster of nodules on his temple. Stein wrote of his experiences with the drug at Carville:

Whether I was to take the oil externally, internally, or - as someone once said - eternally, was up to me. The oral doses were nauseously given out in the cafeteria at mealtime. The injections were administered in what to me was a distressingly public manner...the after effects were sometimes frightful - painful suppurating abscesses which the chaulmoogra oil would generate in the patient's backside...I was hospitalized several times with chaulmoogra-induced, rear-end ulceration.¹⁶

Then in the 1940s there came a dramatic breakthrough that offered patients new hope that they might overcome the disease and be free to leave Carville. Guy Faget, the Medical Officer in Charge, began clinical trials at the hospital in 1941 with a compound called promin, which belonged to a class of drugs known as sulfones. By late 1943, Faget and his colleagues published the first results of their promin studies, which were very promising. Further research confirmed the effectiveness of promin and certain other sulfones in the treatment of leprosy. The drugs could control the infection and render a patient bacteriologically negative. Betty Martin called the story of her struggle with leprosy *Miracle at Carville* in reference to the seemingly miraculous success of the sulfones in treating the disease.¹⁷

Reform Efforts at Carville

The promise of the sulfones served to intensify a movement among the patients at Carville for reform of PHS policies relating to the segregation of leprosy patients. In the early 1940s,

they won a small victory by persuading the administration to permit visitors at Carville. Then in 1943-44, Stanley Stein ran a series of articles in the patient newspaper that he edited, *The Star*, criticizing many of the rules and regulations governing the leprosy hospital. The series was provocatively titled *Carville's Bill of Wrongs*.¹⁸

Late in 1945, Stein organized the United Patients' Committee for Social Improvement and Rehabilitation to serve as a lobbying group for reform. An American Legion post had been established at Carville years earlier by a group of veterans at the hospital, and the Legion had also become a supporter of the efforts to reform policies concerning leprosy. At the 1945 national convention of the Legion, a recommendation was made to the PHS Surgeon General that he appoint a national advisory committee on leprosy. In March, 1946, PHS officer R. C. Williams wrote to Dr. E. K. Kellersberger of the American Mission to Lepers: *There has been a good deal of agitation among certain of the patients at Carville against the general policy of segregation of lepers. We are planning to organize an advisory committee to study the problem.*¹⁹

A National Advisory Committee on Leprosy was appointed to conduct a comprehensive review of leprosy policies. The group, which held its first meeting in May of 1946, consisted of PHS staff, state health officers, leprosy specialists, and representatives from the American Legion and leprosy organizations. In December, 1946, the Advisory Committee issued a series of recommendations, many of which addressed concerns expressed by the patients. Among the recommendations were a more liberal policy of leave for patients, a more effective program of leprosy eradication and control based on a public health rather than an institutional approach, establishment of diagnostic and later treatment centers in the four states where leprosy was endemic (California, Florida, Louisiana, and Texas), provision of financial assistance to families where the breadwinner was undergoing treatment for leprosy, and improvement of recreational facilities and vocational training programs at Carville.²⁰

At least one of the recommendations, giving patients leave for periods of up to a month twice a year, was implemented, but proponents of reform grew impatient at the slow progress

on other fronts. Veterans groups in particular lobbied for Federal legislation to improve the leprosy situation in the United States. Various bills were introduced into the House and Senate in the late 1940s and early 1950s, but none of them ever reached the floor.

The unsuccessful fight for legislation was led by retired Army Colonel G. H. Rarey of the American Federation for the Physically Handicapped, a strong opponent of compulsory segregation. Rarey argued that leprosy was only *feebly communicable*, and that leprosy patients were uniquely discriminated against since individuals suffering from or carrying much more contagious diseases (such as typhoid carriers) were not segregated or greatly restricted in their activities, even though they represented a greater public health threat. In the half a century of existence of the hospital at Carville, he noted, not a single member of the medical or nursing staff had contracted the disease. Fear of being forcibly confined to an institution, according to Rarey, also led many leprosy sufferers to conceal their disease rather than seek treatment for it. In addition, he believed that the practice of compulsory segregation contributed to irrational public fears about the disease.²¹

The advocates of reform, however, did manage to have some changes made in the period. The electorate of Louisiana voted to give residents of Carville the vote, a right they had previously been denied, in 1946. Patients were then confronted with the requirement that they use their real names, rather than aliases, when registering to vote, and a slight majority decided to exercise their franchise at the first opportunity (with the percentage increasing in later years). Louisiana also removed leprosy from its list of quarantinable diseases in 1950.²²

The year 1948 saw several changes desired by the patients. A post office substation was established at the hospital, although the process of sterilizing all mail leaving Carville (which had apparently begun in the 1920s) continued. Two other encouraging developments occurred that year. One of these, the removal of the barbed wire from the top of the fence surrounding the hospital compound, was largely symbolic. A more substantive change was a new medical discharge policy which allowed a pa-

tient to be released while still in the so-called *communicable stage* of the disease. Such a discharge would be granted only when the following conditions were met: the patient's family could pay for outpatient treatment by a physician who would provide monthly reports to Carville, the local health authorities gave their approval, and the household where the patient would live contained no children and few adults.²³

In other areas, reformers continued to run into difficulties. Efforts by the PHS in the late 1940s to convince the railroads to allow leprosy patients to travel on trains without requiring a private compartment were not successful. The PHS was informed that *regardless of the medical situation*, it was believed that *the public generally would not appreciate that situation* and so leprosy patients *must avail themselves of room accommodations*.²⁴ An attempt by the Medical Officer in Charge of the hospital to discontinue the sterilization of mail from Carville in 1958 also failed when the Post Office resisted.²⁵

Patient activists such as Stanley Stein were also unhappy about the hazardous duty pay status of staff at Carville because they felt this helped to perpetuate the myth that being in contact with leprosy patients was especially dangerous. Stein also believed that the incentive of this extra pay caused some hospital employees to resist changes in certain procedures, such as sterilization of mail, which helped to convey the impression that leprosy was more contagious than it actually is. Even the Medical Officer in Charge recognized that the attempt to end mail sterilization might be perceived as a threat to *hazard pay* (which he preferred to think of as *incentive pay*) by certain members of the staff.²⁶

Policies were complicated by the fact that there was not complete agreement among PHS staff as to the dangers of contagion and the need to isolate leprosy patients. In a 1940 report, PHS leprosy expert George McCoy stated: *While there may be great differences of opinion about the value of segregation it seems reasonably clear that, as practiced in the United States as well as in the remainder of the world, it has had no appreciable influence in restricting the spread of leprosy*. As McCoy's words suggest, not everyone shared this view.²⁷

At a 1950 meeting of key PHS staff to discuss the Service's policies towards leprosy, there was *some difference of opinion* on the question of isolation based upon *fundamental differences of opinion concerning the infectiousness of the disease*. Lucius Badger, in charge of leprosy investigations at the Service's Communicable Disease Center (now the Centers for Disease Control and Prevention), had particularly conservative views on this subject. Badger was not convinced that the disease was only mildly communicable, and believed that the PHS should aim at the maximum degree of isolation. He saw segregation of leprosy patients as the key to controlling disease. Although questions were raised about the hospital's recently liberalized policies on leave and medical discharge for patients, the majority of the group approved of them. The group also concluded that *every effort should be made to inculcate the point of view that Carville is a hospital and not a prison*.²⁸

The appointment of Edward Gordon in 1953 to replace F. A. Johansen, who was very popular with the patients, as Medical Officer in Charge eventually led to a crisis at the hospital. Gordon initiated a series of changes which greatly antagonized the patients. A more cautious policy towards contagion led the administration to ban activities such as golf, baseball, and dancing between patients and outsiders. It was also announced that private cottages on the ground occupied by some patients would be torn down and the occupants housed in apartments and required to take their meals in the cafeteria. The patients rebelled and forced the PHS to replace Gordon in 1956 with Edgar Johnwick, who Stein described as having a gift for working with people. Johnwick managed to improve the climate almost immediately.

Ironically, one of the unpopular changes that Gordon tried to implement was to require physically able-bodied patients whose disease was arrested to leave Carville. In spite of the fact that the patients favored more liberal policies for discharge from the hospital, they were opposed to anyone being forced to leave. They pointed out that patients who had come to Carville in the pre-sulfone era had in some cases been there for many years, may have lost ties with friends and family, and would still be subjected to discrimination because of the stigma of the dis-

ease. When Johnwick became Medical Officer in Charge, he assured the patients that no one would be discharged from the hospital against his will and no one would be kept there against his will.²⁹

Conclusion

Since the 1950s, Carville has focused on patient rehabilitation, research on leprosy, and education about the disease primarily aimed at health professionals.

In 1980, the hospital officially became the Gillis W. Long Hansen's Disease Center, named after the Congressman who played a major role in keeping it operating when the other PHS hospitals were closed in 1981. Today there are about 140 permanent resident patients at Carville, most of whom have lived there for many years. Although the hospital stopped accepting new long-term residential patients in 1986, patients do come to the hospital for short periods for treatment or rehabilitation purposes.

The estimated 6,000 leprosy sufferers in the United States are no longer forced to be confined in Carville or other institutions, but are generally treated on an outpatient basis. The Hansen's Disease Center, for example, operates 10 regional ambulatory care facilities. Although the stigma of the disease may not have been completely removed in the public's mind, it has been significantly lessened. Individuals afflicted with leprosy no longer need to be *exiles* in their own country.

President Clinton recently signed a law that transferred the hospital complex at Carville back to the state of Louisiana. It is scheduled to become a school and training center for at-risk youth.

The 135 remaining resident patients will either be relocated to a new residential facility or will receive an annual stipend for life if they elect to live on their own. The other programs of the Gillis W. Long Hansen's Disease Center will also be relocated.



An aerial view of the U.S. national leprosy hospital at Carville, Louisiana. (Courtesy of U.S. Department of Health and Human Services).

BIBLIOGRAPHY AND NOTES

1. STEIN S. (with BLOCHMAN L.), *Alone No Longer: The Story of a Man Who Refused to be One of the Living Dead*. Carville, LA, The Star, 1974 (original edition published in 1963), pp. 3-4.
2. STEIN S., ref. 1, p. 21. I will use the term leprosy rather than Hansen's disease in this paper because I am dealing with the subject in its historical context.
3. MARTIN B., *Miracle at Carville* (edited by WELLS E.). Garden City, NY, Doubleday, 1950, pp. 8, 14.
4. MARTIN B., ref. 3, pp. 282-303. BLOCHMAN L., *Epilogue: The Torch is Passed*. In: STEIN S., ref. 1, p. 343.
5. DYER I., *The History of the Louisiana Leper Home*. New Orleans Med. Surg. J. 1902; 54: 714-737. REEVES S., REEVES W., *National Register Evaluation Gillis W. Long Hansen's Disease Center: The Final Report*. Carville, LA, U.S. Department of Health

- and Human Services, 1991, pp. 27-31. CALANDRO C., *From Disgrace to Dignity - The Louisiana Leper Home, 1894-1921*. M.A. Thesis, Louisiana State University, 1980.
6. REEVES S., REEVES W., ref. 5, pp. 31-39. CALANDRO C., ref. 5. FURMAN B., *A Profile of the United States Public Health Service 1798-1948*. Washington, D.C., U.S. Department of Health and Human Services, 1973, pp. 311-312, 347-349.
 7. *Regulations for the Government of the United States Public Health Service*. Washington, D.C., Government Printing Office, 1920, pp. 147-148.
 8. ROSEN G., *A History of Public Health: Expanded Edition*. Baltimore, Johns Hopkins University Press, 1993, pp. 38-41 (quotation on p. 38).
 9. GUSSOW Z., *Leprosy, Racism, and Public Health: Social Policy in Chronic Disease Control*. Boulder, CO, Westview Press, 1989. GUSSOW Z., TRACY G., *Stigma and Leprosy Phenomenon: The Social History of a Disease in the Nineteenth and Twentieth Centuries*. *Bull. Hist. Med.* 1970; 44: 425-449.
 10. GUSSOW Z., ref. 9, pp. 130-131. HUTCHINSON E., *Legislative History of American Immigration Policy 1798-1965*. Philadelphia, University of Pennsylvania Press, 1981, pp. 416-419. *Quarantine Laws and Regulations of the United States*. Washington, D.C., Government Printing Office, 1899, p. 27.
 11. REEVES S., REEVES W., ref. 5, p. 28.
 12. GUSSOW Z., ref. 9, pp. 152-153. *Regulations*, ref. 7, pp. 147-148.
 13. MARTIN B., ref. 3, pp. 109-110, 114, 146-147.
 14. *Passes for Carville Patients* (typescript dated 1954). *Public Health Service Hospitals Historical Collection, 1895-1982*, MS C 471, History of Medicine Division, National Library of Medicine, Bethesda, MD, box 12, folder 12.
 15. McCOY G., *Chaulmoogra Oil in the Treatment of Leprosy*. *Pub. Health Rep.* 1942; 57: 1727-1733.
 16. STEIN S., ref. 1, pp. 38-39.
 17. PARASCANDOLA J., *Sulfones and the Miracle at Carville*. *Rev. Hist. Pharm.* 1996; 44 (no. 312): 409-412.
 18. GUSSOW Z., ref. 9, p. 164.
 19. STEIN S., ref. 1, pp. 231-232. WILLIAMS R. to KELLERSBERGER C., March 1, 1946, Record Group 90 (Public Health Service), National Leprosarium 1945-1966 (NN3-090-91-003), box 1, National Archives, Washington, D.C.
 20. STEIN S., ref. 1, pp. 223, 239. *Recommendations of the Advisory Committee on Leprosy in the United States Made at the Meeting in Washington, D.C. December 17, 1946* and list of Advisory Committee members (typescript documents), Record Group 90, ref. 19, box 1.
 21. STEIN S., ref. 1, p. 244. GUSSOW Z., ref. 9, p. 167. RAREY G., *The Case Against Compulsory Segregation in Leprosy* (printed document). *Public Health Service Hospitals Historical Collection, 1895-1982*, ref. 14, box 13, folder 11.
 22. STEIN S., ref. 1, pp. 236-243.
 23. STEIN S., ref. 1, pp. 240-243. JOHNWICK E., *Sterilization of Mail* (memorandum to Chief, Division of Hospitals), August 15, 1958. *Public Health Service Hospitals Historical Collection, 1895-1982*, ref. 14, box 12, folder 13.
 24. *Passes for Carville Patients*, ref. 14.
 25. STEIN S., ref. 1, p. 241. *Sterilization of Mail*, ref. 23. RILEY E. to SURGEON GENERAL, August 26, 1958, *Public Health Service Hospitals Historical Collection, 1895-1982*, ref. 14, box 12, folder 13.
 26. STEIN S., ref. 1, pp. 233-235. *Sterilization of Mail*, ref. 23.
 27. McCOY G., *Leprosy in the Continental United States*. Record Group 90, ref. 19, box 1, p. 43.

28. *Meeting of February 27, 1950, to Discuss Public Health Service Policy Matters in Connection with Leprosy* (typescript) and HUNT G., *Draft on Public Health Service Policy on Leprosy* (memorandum), March 3, 1950, *Public Health Service Historical Collections, 1895-1982*, ref. 14, box 12, folder 9.
29. STEIN S., ref. 1, pp. 303-314. GUSSOW Z., ref. 9, pp. 170-175.

Correspondence should be addressed to:
John Parascandola, 18-23 Parkdawn Building, 5600 Fishers Lane, Rockville, MD 20857, USA.