Philip King Brown and Arequipa Sanatorium: Early Occupational Therapy as Medical and Social Experiment

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MeSH TERMS
- hospitals, chronic disease
- human activities
- occupational therapy
- tuberculosis

Historical inquiry enriches occupational therapy practice by identifying enduring values and inspiring future excellence. This study presents for the first time the pioneering life and work of Philip King Brown, a San Francisco physician who used occupation to treat the physical, mental, and social effects of tuberculosis (TB) at Arequipa Sanatorium, the institution he founded in 1911. Through textual analysis of the Arequipa Sanatorium Records, this article evaluates and defends Brown's assertion that his institution was medically and socially experimental. The Arequipa Sanatorium promoted occupational therapy by demonstrating its viability in the treatment of TB, the era's most critical health threat. It also put into practice the ideals of holism, humanism, and occupational justice that resonate within the profession today. Finally, Arequipa provided an example of how an occupation program can change the public perception of disability.


During the first decades of the 20th century, a vanguard of doctors advanced a new medical model that used occupation to effect cures and maintain wellness. This innovation took place in the context of remarkable nationwide interest in social reform known as the Progressive Era (Starr, 1986). The contributions of Herbert Hall and William Dunton to the profession and practice of occupational therapy are well documented (Bing, 1992; Reed, 2005). Less familiar is the name of Philip King Brown. Although Brown is not formally recognized as a founder of occupational therapy (Peloquin, 1991), his vision for occupation as a force for social justice qualifies him as one of its more important pioneers. At the Arequipa Sanatorium for Tuberculous Wage-Earning Girls, the California institution he founded and ran, Brown implemented occupation as a means to combat his era’s most critical health threat: tuberculosis (TB). Brown garnered nationwide acclaim, documented success with an underserved patient population, and helped change the public’s expectations regarding people with disabilities (Cabot, 1912).

This article documents and explicates the work of Philip King Brown with the intent to enrich our understanding of core professional values and to inspire future excellence. Although Brown has been named an influential early proponent of occupational therapy (Quiroga, 1995), no studies detail his work. This research was guided by the question, What was Brown’s contribution to occupational therapy practice?

Method

This article takes a historical research approach, a multistep critical process involving (1) formulation of the research question; (2) collection of source materials, with a focus on primary sources; (3) evaluation of source materials for external and internal consistency; (4) synthesis of information; and (5) interpretation and formulation of conclusions (Weisma, 1995).

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The University of California, Berkeley’s Bancroft Library provided access to the Arequipa Sanatorium Records, which comprise such primary sources as letters (by both the administration and patients), in-house publications, patient files, photographs, public records, and annual reports. Many of the records were authored by Brown between about 1910 and 1928, a period that encompasses the planning period of Arequipa and his tenure as its director. Brown’s writings address various audiences (e.g., fellow sanatorium directors, donors, patients) and allow for comparisons across time and situation, thus revealing both consistency in and evolution of thought. Writings by patients and other staff members provided a valuable check on Brown’s self-representation, whereas newspaper articles gave insight into the public’s perception of Arequipa.

The Arequipa Sanatorium Records are inherently biased toward the administration’s perspective and values because members of the administration, rather than patients or low-level workers, collated them after Brown’s death. Therefore, this article focuses on what the records most thoroughly and reliably document: Brown’s leadership at Arequipa. Scholarship about sanatoria and the anti-TB movement constituted this article’s secondary sources, valuable for illuminating the medical and societal context that shaped Brown and Arequipa.

Of priority were themes related to occupational therapy practice that Brown frequently articulated both within and across documents—for example, occupation, physical and mental illness, disability, and independence. This article sets these themes within a narrative arc about one man’s life’s work.

Findings are presented in three sections. The first introduces Brown and traces how his professional interest in occupation matured, reaching fruition in Arequipa. The second examines Brown’s use of occupation to benefit his patients both medically and socially. The final section summarizes Arequipa’s impact then and now.

Brown and Arequipa

Brown’s Background and Influences

Holism, humanism, and a keen sense of what would today be called occupational justice distinguished Brown’s professional endeavor. A Harvard-educated general practitioner with access to the highest reaches of San Francisco society (Brown, 1914), Brown directed his considerable energy toward the threat of TB and a medically deprived population. Before founding Arequipa, Brown directed the San Francisco Polyclinic for several years (Brown, n.d.-b).

There, Brown trialed the approach that, in more ambitious form, would characterize Arequipa. Close observation of his patients convinced him of the interconnectedness between person, occupation, and environment: “Every effort is made to study all of the physical, social, and financial aspect [of each patient]” (Brown, n.d.-a, p. 6). Under Brown’s direction, visiting nurses recommended changes in environment and nutrition and educated at-risk families about hygiene (Brown, n.d.-a). Brown often focused interventions on employment. He realized that sustained access to a more healthful lifestyle required income. Such attention to person, occupation, and environment foreshadowed contemporary occupational therapy theories.

Brown’s concern for women’s health—remarkable for his time—can be credited in part to his mother’s influence. Charlotte Blake Brown was a leader in women’s and children’s health and one of San Francisco’s first female physicians (Quiroga, 1995). Brown concluded from his own statistics that the TB rate among working-class women was twice that of men (Brown, n.d.-b). He attributed this difference to the environment to which women’s roles conspired them:

The opportunities that are open to women are distinctly against them, not only being conducive to the acquiring of tuberculosis, but offering a minimum of opportunity for recovery under the present conditions. As dressmakers, stenographers, clerks, factory workers, etc., they are often where the most unsatisfactory conditions in business life are found. The outdoor occupations, which are plentiful for men in California, are hardly open to them at all. (p. 7)

Not only were working women particularly vulnerable to infection, Brown noted, but they were also uniquely deprived of medical attention. Because women’s work continued inside the home, they never had the opportunity to rest and recuperate. Moreover, they could not afford sanatorium care, the most highly regarded treatment. Brown realized that a successful remedy for women would have to consider diverse aspects of patients’ lives, including their vocational prospects, financial realities, and gender roles.

Brown’s concern for the welfare of poor, tubercular women was exceptional. Humanistic values were more narrowly applied in early 20th-century America than they are today (Trattner, 1999). Apart from women, discriminated groups included the poor, disabled, and non-Protestant white populations. People infected by TB were especially stigmatized because the disease connoted low morality and complacent dependency (Craddock, 2000).
Brown (n.d.-a) recognized that women had both individual and societal value: As guardians of family well-being, recuperated women would inform their families about hygiene practices and raise healthy children.

**Creation of the Arequipa Sanatorium**

To wealthy investors, Brown portrayed Arequipa as an enlightened health facility that would ameliorate disease and social dependency through a mixture of occupation and medical science (Brown, n.d.-a). He described Arequipa as a place “where young women could [go] with their early tuberculosis and be cared for at a rate within their means with no element of charity and with the opportunity of earning part or all the cost of some form of work which they could do safely” (Brown, 1914, p. 327).

Brown proved persuasive. In a short time he acquired, through the generous gifts of his society friends and acquaintances, land in Northern California’s Marin County and sufficient money to begin building:

> Within a few months $20,000 had been spent in providing a very complete plant for 24 patients, including water supply and sewage system, a laundry, a stable and equipment, servants’ building, work building and cottage for the visiting physicians and managers. (Brown, 1914, p. 327)

Arequipa Sanatorium opened on September 9, 1911, with five patients. The “safe work” to which Brown referred was ceramic manufacture. Brown hired the well-known ceramist Frederick Rhead to run Arequipa Potteries and to oversee the training of patient employees (Downey, 2000). The pottery was not the only source of therapeutic occupations at Arequipa, but it was arguably the most ambitious and prominent.

**Occupation as Medical and Social Treatment**

In its emphasis on both a social justice and an occupational approach to health, Arequipa was an unusual and groundbreaking institution. Brown (1913) referred to it as a “medical and sociological experiment” (p. 4) because he used occupation both to treat medical illness and to address social inequality.

Medically, Arequipa was daring in that it endorsed occupation rather than rest as the treatment of somatic illness. At the beginning of the 20th century, most physicians viewed activity as dangerous to invalids because it supposedly diverted the body’s energy away from fighting disease (Dormandy, 1999). Sanatoria—the era’s most respected tool for combating TB—constituted environments where doctors could carefully monitor patients’ adherence to a strict regimen of hygiene, rest, and diet, commonly known as the *rest cure*. When activity did feature in the typical sanatorium regimen, it was treated as an evil necessary to address physical or practical issues—for instance, to stimulate the appetite or to defray institutional costs. The perceived dangerousness of activity was reflected in doctors’ obsessive attempts to control it and in efforts to differentially protect wealthier patients from it (Dormandy, 1999).

Brown identified a larger therapeutic purpose for activity. He recognized that getting patients out of bed conferred important physical benefits as well as some risks that required oversight by a health professional (Brown, n.d.-b). He believed, however, that the most beneficial activities would also be those that interested the women.

Brown (1913) designed his work program to harness their motivation:

> Their need for work and the interest offered by work during the period of recovery, as well as their need for the opportunity to earn toward their own support while in the Sanatorium, were all factors in the minds [sic] of the founder. (p. 9)

He was gratified by the results, noting, “Many patients have begun to improve only after the work has begun. . . . A wholesome atmosphere of happiness and hope pervades the whole sanatorium on those days when the girls are at work” (Brown, 1917, p. 394). Moreover, patients could choose which occupations to take part in or whether to participate at all. In acknowledging the connection between the patients’ attitude toward the activity and its therapeutic efficacy, he asserted a collaborative approach, relinquishing some of the absolute power espoused by most doctors of his era (Teller, 1988). By understanding the importance of the patient’s engagement in the process, Brown created the opportunity for patients to translate mere activity into meaningful occupation.

**Influence of Herbert Hall’s Work at Devereux Mansion**

It appears that Brown shared a negative view of the rest cure with Herbert Hall, one of the founders of occupational therapy. Hall directed a workshop for people with neurasthenia (nervous disorder) at Devereux Mansion in Marblehead, Massachusetts. He dissented from the common wisdom that rest would soothe the nerves by replacing the chaos and complexity of modern life with calm and order (Anthony, 2005). Hall (1917) proclaimed, “It seems clearer now than ever before that idleness, long continued, is a menace not only to the
In contrast, Brown was sensitive to the heavy psycho-
logical toll TB took on his patients, and he championed occupation as a means to harness mental power to do the work of physical recovery. Brown (1915) declared,

>Tuberculosis is a depressing disease and the usual idleness of an outdoor cure gives patients too much time to think, and, that the diversion offered by interests outside themselves is often essential to cure. We are convinced that this is frequently true. (p. 17)

**Remunerative Occupation**

Brown and Hall also agreed that work’s therapeutic benefit increased to the extent that it had authentic social value—most clearly measured in dollars and cents. For this reason, Hall (1905a) stressed that a workshop had to “be the real thing, not a mere play shop” (p. 49). Remuneration was understood as proof of societal usefulness, which would promote pride and satisfaction in both life and work. According to Gutman (1997), vocational reeducation was a key area of occupational therapy in the years from 1910 to 1920. Arequipa provides one of the most successful and ambitious examples of this emphasis.

At Arequipa, women working at the pottery earned wages to pay for their stay. The patient–workers received pay even before the pottery turned a profit, and wages were often higher than the women could have expected in San Francisco. Brown (1917) reported that over the 5 years of the pottery’s existence, of the 66 patients who worked at the pottery, 24 had earned a competitive hourly wage from their work in the pottery, and several went on to work in ceramics after they left Arequipa. More important, no patient was coerced into making pottery. Those who opted out did not jeopardize the quality of their treatment.

Arguably, the working-class women who stayed at Arequipa had even more to gain from remuneration than Hall’s affluent neurasthenics. First, the Arequipa patients would be able to afford longer stays in the sanatorium, thereby increasing their chances at cure or at least remission. Second, they would learn middle-class work skills that would qualify them for access to higher wages and more healthful work environments. Third, they would stave off the stigma of dependency by continuing to prove themselves viable, committed workers. Beyond immediate gains in mental health, Brown envisioned long-lasting holistic benefits. He wanted treatment to have a long-term effect on his patients’ lives, awakening new potentials for social status and health: “A number [of patients] are ready to be discharged and are desirous of continuing this work... This is a most gratifying and satisfactory proof of the interest in the work and its remunerative possibilities” (Brown, 1912, p. 5).

Brown (1917) found in pottery an occupation which is not only fascinating, but also safe and suitable. It can be done in the open air or in a screened enclosure. It can be done in wet clay to eliminate dust, and the product can be easily sterilized. (p. 394)

The difference in the Arequipa program was that the patients had a physical illness instead of a so-called mental one. Brown’s willingness to transfer work cure ideas to treating patients with TB challenged a long-standing taboo.

Brown and Hall believed similarly that occupation produced a state of self-forgetfulness necessary for allaying worry and promoting wellness. Worry was a key symptom of neurasthenia, but the psychological state of the TB patient was regarded as relatively unimportant by the majority of doctors who concentrated on the physical aspect of the disease. According to Teller (1988), the era’s medical techniques for reducing contagion were crude and sometimes cruel: Patients were isolated from their families and communities. They were expected to exchange productive, busy lives for ones limited to rest. Public health programs even had license to destroy or rebuild neighborhoods to displace diseased populations. Clearly, psychological health was generally a low priority. In contrast, Brown was sensitive to the heavy psycho-

When looking for suitable occupations for his patients with TB, Brown (1914) explicitly took inspiration from Hall:

>The idea of making pottery came to us from Dr. Hall, who conducts at “Devereux Mansion,” Marblehead, Mass., a remarkable institution for the care of nervous cases, in connection with which is a successful pottery, where part of the work is done by the patients. (p. 328)

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After the Arequipa pottery succumbed in 1918 to soaring raw material prices at the outbreak of World War I, Brown reinvented his vocational program. He developed a laboratory technician training course, which taken in conjunction with stenography and shorthand, would transform a woman of average education into a person “invaluable to doctors” (Brown, 1922, p. 27). Arequipa provided an excellent, real-life training ground for such work because laboratory assistants could learn on the job, making the tests for the sanatorium. Brown (1922) reported that three recent ex-patients—whose advanced illness prevented them from advisedly returning to their prior employment—were “earning a good livelihood” (p. 27) thanks to the job training they received at Arequipa. For one person, previously a domestic worker, becoming a laboratory assistant entailed a significant rise in social and economic standing. In such women, Brown realized his dream of the sanatorium fulfilling health, social, and economic goals.

Brown’s Contribution and Its Relevance to Contemporary Practice

History provides us with an understanding of our roots. Knowledge of past leaders provides today’s occupational therapists with an awareness of the values and beliefs held by previous generations so that we may more readily see the core of occupational therapy practice and understand how the values of the past resonate within the profession today. It is our conclusion from our examination of Brown’s work at Arequipa that he was indeed a pioneer in occupational therapy and should be recognized as such. This article demonstrates how he helped expand and promote the role of occupational therapy and to epitomize and broaden its core values—values that are reflected today in the Occupational Therapy Practice Framework: Domain and Process (2nd ed.; American Occupational Therapy Association, 2008).

Leading Reformer for Social Justice and Occupational Justice

Prompted by his concern for patients of limited means, Brown took the unprecedented step of creating Arequipa Sanatorium specifically for working-class women with TB. At Arequipa, he provided the women with an opportunity to engage in meaningful occupation that would not only lead to their recovery but also provide them with future economic stability. Judged by Progressive Era standards, this undertaking was extraordinary. Richard C. Cabot (1912), a Harvard medical professor, described the “experiment of trying to make handicapped people self-supporting” as “a Utopian project. . . . What is done at Arequipa is done, so far as I know, nowhere else in the world.” To our knowledge, Brown is the only one of the founding generation of occupational therapists to explicitly champion the cause of social justice by creating a program specifically for the underserved. It is noteworthy that he was a pioneer in advocating for occupational justice 100 years before the term was introduced into the occupational therapy lexicon (AOTA, 2008).

Pioneer in the Use of Occupation With People With TB

Like other progressive founders of occupational therapy such as Hall, Brown used a holistic approach in the treatment of his patients, recognizing that one’s emotional state affects one’s physical health. The medical community did not hold this position in regard to TB at that time. By the 1920s, however, the approach Brown used had risen to prominence throughout the country. TB sanatoria in the United States had dispensed with the rest cure and prided themselves on occupational therapy workshops in which men and women recovered not only their health but also their belief in themselves and their sense of usefulness (Kidner, 1922).

Advocate for Women’s Health

At a time when women did not even have the vote, Brown recognized the important role that they played in the home and founded a program specifically for them. As noted, it is likely that he was influenced by his mother’s lifelong devotion to women’s health as a surgeon and cofounder of San Francisco Children’s Hospital (Downey, 2000).

Pioneer in Prevocational Occupational Therapy

Brown understood that the women in his program could better retain their health once they left Arequipa if they had skills that could be used in the workplace. Like Hall, he created a workshop setting in which patients could engage in meaningful occupation that might also lead to a new profession. The Los Angeles Tribune distinguished Brown as “a man who believes in work for every one, but who believes especially in giving the handicapped a chance” (“A Workshop Home for Girls,” 1913).

Creator of a Cultural Change in Attitude Toward People With Disability

During the time Brown was practicing, an influx of World War I veterans awakened the public to the need to promote programs that enabled people with disability and chronic illness to become productive members of society (Ambrosi & Schwartz, 1995). Thomas Kidner (1930), one of the founders of occupational therapy, asserted that
the war convinced Americans “that every possible effort should be made to assist a disabled man to overcome the handicap of his disability” (p. 38). Arequipa served to remind the populace that working-class women with chronic illness also had great potential to contribute to society. The Los Angeles Tribune (“A Workshop Home for Girls,” 1913) profiled Brown’s endeavor of “making the girls self-supporting in a sanatorium, once they are physically handicapped and made unequal to the commercial struggle.” Beyond Arequipa, Brown’s position as associate medical director of the Red Cross and assistant director of the Department of Medical Research and Intelligence (Downey, 2000) created the opportunity for him to promote occupational therapy within the national rehabilitation effort (Brown, 1923). Moreover, Brown’s commitment to changing society’s view of people with disabilities and to providing them with worthwhile occupation was a lifelong goal. He exhorted,

Let us not speak of a one armed, one eyed, or one legged man, or think of a locomotive engineer who is discovered to have heart disease as lost to full usefulness. Let us make the most of the potential efficiency of what remains, and not measure what is gone. (Brown, 1923, p. 178)

Role Model for Today’s Practitioners

As Schwartz (2009) highlighted in her Eleanor Clarke Slagle Lecture, the founders of occupational therapy harnessed their strength of character and formidable leadership skills to create a new profession; their skills included “confidence, courage, hard work, creativity, and a willingness to take risks” (p. 612). Brown displayed similar strength and skill in founding Arequipa and developing its program. A memorial to Brown includes the following statement from an admiring fellow doctor:

Doctor Brown’s independent point of view, his uncompromising character and vigorous presentation of his beliefs and convictions will be missed in the council of his colleagues; but his kindly ministrations, his human feeling, and his great professional skill will be even more a loss to the sick and suffering in the wards, clinics and sick rooms accustomed to his gracious presence. (Robert Porter, quoted in Metzger, 1941, p. xlviii)

This combination of conviction, independence, and compassion is one that occupational therapists should aspire to today as we face the challenges of the 21st century. Many of Arequipa’s problems still resonate as present-day occupational therapists challenge themselves to provide meaningful, respectful, and efficacious inter-
ventions to patients who differ from them in terms of culture and social status. Brown’s therapeutic program is as relevant in 2012 as it was in 1911 in its occupation-centered, humanistic approach addressing the psychological and physical aspects of disability and concerned with occupational and social justice. Brown’s work highlights the critical role of occupation in society. Probably the most moving testimony to this role is expressed in a poem written by one of the graduates of Arequipa:

Here, where ’tis ever balmy Summer Time,
The Potters find that Action outweighs Speech,
And work accomplished braces more than Wine;
That the Strong Spirit conquers Death and Fate,
And shapes the Funeral Urn to hold gay Flowers,
And out of Grief and Fear may frame Delight (“The Pots of Arequipa,” 1919, quoted in Downey, 2000, p. 34)

This poem reminds those of us today of the magnificent power of occupation to heal, a power that has existed since long before the profession was founded. ▲

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