

An undertaker who within the last ten years has buried many of the ten thousand of our people who sleep in Southview cemetery recently made a remark to me that set me to thinking. I give it to you tonight with the hope that it may have the same effect upon you. "You have no idea," he said, "how many people are dying from the lack of sympathy." This is expert testimony, and we cannot reject it.

—Rev. H. H. Proctor, "The Need of Friendly Visitation," 1897

The chief interest in the South is social supremacy, therefore prejudice manifests itself most strongly against even an imaginary approach to social contact.

—Fannie Barrier Williams, "A Northern Negro's Autobiography," 1904

INTRODUCTION

Disease Histories and Race Histories

In late September 1920, the case of Alice Barnes and her family was referred by the Baltimore Family Welfare Association to the Henry Watson Children's Aid Society (HWCAS). Soon thereafter, the HWCAS sent its agent, S. S. Lawrence, to Barnes's residence, a rented room in a "two story, six room house on a broad, smoothly paved street, in a rather nice section of the city" in which Barnes and her two-year-old daughter, Eleanor, had lived for nearly two months.¹ Alice Barnes was aware that she was dying and wanted

to make provision through the society for the care of her toddler and her newborn infant. Although Barnes awaited the results of a sputum test from the City Health Department, Lawrence could quickly discern from pieces of evidence strewn about her room that the woman was in the final stages of pulmonary tuberculosis, or consumption. Two sputum cups, one containing a germicidal solution of chloride of lime (as precaution against infection of others), showed that a visiting nurse recently had been on the premises. They stood on the floor, next to the bed and near the foot of a small nightstand on which stood a glass of milk, Barnes's usual fare until the woman from whom she rented the room returned home to prepare dinner. Other signs told the tale of disorder caused by disease. Having gained entrance from an unscreened window on one side of the room, a "great many" large and menacing flies danced through the stifling late summer air. Many of them alighted on Alice Barnes, who, sitting languidly on the edge of her bed and struggling for breath, barely had the energy to brush them away. In contrast to the room, Lawrence noted, Barnes was "a pretty, light skinned, colored woman with long silky hair," no doubt leaving any visitor unused to the scene with the impression of witnessing a modern, twentieth-century comment on what only a generation before widely had been regarded as a "romantic" affliction. As Lawrence helped her into the bed, Barnes, "very slowly and in a whisper," began the ritual part of every case in the era of modern charity and social work, the telling of her history.

For reasons Barnes did not relate or Lawrence deemed not pertinent to the case, in July, Alice; her husband, LaSalle Barnes; and their infant daughter, Eleanor, had come to Baltimore, probably from Northumberland County, Virginia, where the couple had been married in 1915. Her current landlady, Laverne Settles, later reported that Barnes had told her that they had come to the city on vacation. Whom they were visiting, however, is not clear, since Alice's Baltimore relatives, an aunt and two cousins, had had no idea that she was in town. Soon after the family's arrival in Baltimore, however, LaSalle left Alice Barnes, nearly seven months pregnant with her sixth child, to go to Atlantic City, where he said he had found work at "an ice cream place." He was to send for the family once he had begun work and found a place to live. She never heard from him again.

Anxious and running out of money, on 1 August Alice Barnes moved to her current residence, where she paid \$2.50 a week to Settles for room and board. It is not clear why she did not return home to Virginia to her other children.² Holding out hope that her husband would indeed send for her, she may have decided to stay in Baltimore until the birth of her baby. Whatever

her original plans, subsequent events forced her to make drastic changes. Although Barnes claimed to have been in good health, with no reason until recently to suspect that she had tuberculosis, the physical and mental demands of pregnancy and spousal desertion turned the disease active, and she began to exhibit the first signs of the pulmonary form of the disease. It began with sudden and immobilizing fatigue, which became more profound with the approach of childbirth. Her appetite soon left her. With some consternation, Settles noticed her condition and suggested that she go to Hopkins Hospital, which she did. Three days later she delivered Archer, giving him a family name.

Having given birth to five other children, she knew that Archer's incessant crying, which "made her so nervous that she cannot have him in the room," was not normal. Furthermore, he completely refused to nurse, due, unbeknownst to his mother, to the pain caused by tuberculosis of the stomach. At the same time, her condition grew rapidly worse. As the disease ravaged her lungs, she developed a violent and persistent cough that left her hoarse, constantly short of breath, and even more enervated. She had been too weak even to find or make a layette for the baby, and Settles wrapped Archer in a blanket and took him to the city's Welfare Station, returning later with baby formula, which he seemed to enjoy. Thereafter Settles saw to the care of Alice Barnes and her two children. In the mornings, while she worked in a dentist's office, Settles's daughters followed her instructions and attended to the three boarders. In the afternoons, Settles earned extra income as a dressmaker at home and was able to tend to Barnes. Both women knew that the prognosis was bleak, however. Eleanor Barnes seemed to sense it as well, "crying and clinging" to Settles's daughter when the caseworker arrived. With no other options, Alice Barnes had the HWCAS make arrangements for Archer and called her aunt in Baltimore, Judy Lightfoot, to request that she take Barnes home to Virginia to spend her final days with her other children.

Why Alice Barnes had not previously contacted her aunt remains a mystery. Pride may have factored into the decision. Lightfoot, though living modestly, was more well off than her niece. (After a visit to the Lightfoot residence, Lawrence described her and two nieces who lived with her as "all nicely dressed" and "very respectable.") Alice Barnes and her husband, in contrast, had always lived on the brink of poverty. Several years earlier, Lightfoot had raised about sixteen dollars from friends to help Barnes at a particularly bad time. Pregnant and deserted, Alice may have regarded again calling on her aunt as embarrassing. Whatever the circumstances,

Lightfoot had been unaware that her niece was in Baltimore and was “very much surprised to find Alice so sick.” Lightfoot agreed to take Eleanor and said that she was “willing to do anything she can for” the child and her mother, including making the arrangements for Barnes’s return to Virginia, where she died one week later. Archer was placed with a very grateful foster family in Baltimore. Although he at first seemed to be recovering from his illness, Archer succumbed after a violent and convulsive relapse.³

FOR MOST OF THE first half of the twentieth century, tuberculosis ranked among the top three causes of mortality among urban blacks. In 1900, 1920, and 1940, pulmonary tuberculosis accounted for 15.0 percent, 12.8 percent, and 8.4 percent of African American mortality, respectively. A disease resulting mainly from poverty and environmental factors, tuberculosis also ranked quite highly among whites—causing 9.8 percent, 6.7 percent, and 3.2 percent of white mortality in those years, respectively, although black tubercular mortality was almost always higher in any given community. Any African American alive in or before 1940 may well have either known or been closely related to someone who had suffered with or died from tuberculosis. Many lived in fear of it. Many, like Alice Barnes and countless others, coped with it as part of a set of problems common to poor blacks. Others were so completely surrounded by it as not even to remark (as physicians often complained) the appearance of persistent symptoms. Beyond individual experiences, however, modern tuberculosis has always had a socioeconomic and political profile. The majority of tubercular disease cases originated in the airborne travel of the tubercle bacillus to the lungs, thereby making conditions of poor housing what public health scholars today would call a “fundamental cause” of tuberculosis. So, too, were poor nutrition, stress, and overwork. In fact, before the advent of pharmacological therapies in the late 1940s, the best treatments for tuberculosis (and they were more effective in preventing the disease) involved the amelioration of these conditions. A disease that claimed life on this magnitude and in the manner in which it did tells us much about the social context, politics, and culture of Jim Crow.

This context—how individuals, institutions, black and white leaders, and public officials mediated the demands and politics of tuberculosis—is the subject of this book. Eschewing simplistic interpretations that find that southern public health generally neglected blacks or that abstract and archetypically “Progressive” ideals constituted a positive force in improving African American existence in cities despite the limitations of endemic racism,

Infectious Fear argues that integral to the project of modern urban public health were theoretical and practical compromises that moved the politics of black health from absolute neglect to qualified inclusion based on specific notions of care, expertise, public utility, citizenship, social control, and responsibility. This involved specific forms of protest and coalition politics. The idea that, as one white southern physician maintained in 1903, to “the science of medicine must be entrusted the last analysis of the negro problem” was not far removed from the logic that mandated the considerable effort and resources expended in visiting nursing, dispensary services, and sanatorium construction that came in the years to follow.⁴ At the same time, public health’s claims to social expertise did not forcefully extend to the poor living and working conditions at the root of African American tuberculosis. It would fall primarily to blacks within and outside the health professions to make the larger critiques of the political economy of Jim Crow, even while they frequently articulated such criticism in a racial utilitarian language of interdependence that liberal whites might also adopt. Here I distinguish “racial utilitarianism” from “enlightened self-interest,” liberal commentators since Alexis de Tocqueville having used the latter term to describe U.S. political culture, even ascribing to its spirit the cross-color alliances between blacks and whites in the turn-of-the-twentieth-century South. In a departure from such assumptions, racial utilitarianism implies the situated practices, fabricated logics, and habitus in which various actors were disposed to interpret and respond to urban industrial capitalism and its problems (among them the racial order, inequalities, morality, and tuberculosis). Pierre Bourdieu, having described habitus as (among other things) “embodied history,” was particularly interested in such dispositions, as was, on the level of discourse, Michel Foucault.⁵ Evidence of these dispositions was everywhere, transcending many of the political divisions historians take for granted. Black accommodationist arguments could support self-improvement based on institution building and even positive eugenics, even while black protest cited elevated levels of black tuberculosis mortality in its indictments of white racism. The worst white reactionaries saw black tuberculosis as a harbinger of racial degeneration, while Progressives, loathe to make any arguments regarding black equality, maintained that a modern, responsible, public health state owed care to all citizens, aside from any questions of what citizenship actually meant, a line of reasoning to which blacks themselves would give tentative encouragement.

The irony is the relative analytical neglect tuberculosis, an almost inescapable fact of early-twentieth-century life and death, has suffered within

studies of race and politics in the United States. This has not been so because tuberculosis is historically unimportant. Largely in addressing HIV/AIDS and the problems of stigma and poorly managed political responses to infectious crisis, there developed after the early 1990s a renaissance of historical examinations of tuberculosis in the national contexts of, for example, South Africa, Ireland, France, England, Argentina, and the United States.⁶ Like the non-U.S. literature, much of the U.S. work has paid some attention to ideologies and social policies that emphasized the management of working-class domesticity, labor, and political frustrations. However, largely because the social history of African Americans in the “white plague” (as tuberculosis was known colloquially) was not within their scope, these studies have provided only brief discussions of this history.⁷

The failure on the part of historians of African American experiences to make an assessment of tuberculosis politics under Jim Crow is equally understandable, largely the result of a generational amnesia produced by the arrival of chemical cures. An implicit purpose of early historical studies of Jim Crow was the contextualization of *continuing* manifestations of political inequality. By this time (the 1950s), scholars had witnessed dramatic declines in black tubercular mortality and had felt reasonably assured of further reductions through medical interventions. Most therefore focused on the still-unfolding historical dramas of inequality in education, labor, social provision, and housing. To illustrate the point, one might compare the amnesiac postwar historical works to the pre-1945 sociological works on black communities under Jim Crow: the latter are usually cognizant of the relationships between disease morbidity and mortality on one hand and structural racism and ghettoization on the other.

To point out that both historians of public health and historians of African American experiences have neglected black tuberculosis is not simply to argue for an incremental “add race and stir” approach to the subject. The broader reasons why we should revisit the politics of race, reform, and public health are several and important. Because of its etiology and sociomedical profile, tuberculosis, among all the major early-twentieth-century afflictions, may prove best suited to illustrate the historical processes of racial construction of disease and of medical constructions of race. What previous treatments have neglected and what this book emphasizes is that “medical racism” was inseparable from its social and economic frame, part of what Stuart Hall has described as “articulated racism.” The ability to distinguish between races was integral to the larger project of determining causality of infection. This book therefore describes “race” less in terms of supposed

truths of biological difference (including skin color) and more in terms of the multiple ways in which difference and inequality may be articulated, mobilized, and experienced within dynamic political and economic systems.⁸

In this regard, historical examinations of the politics of Jim Crow public health and medical racism provide opportunities to give meaning beyond the passive voice to the now axiomatic phrase “Race is constructed.” Contests over the meaning of racial ideas have occurred at times and in places where balances of power have been in flux. Depending on their point of view, contemporaries a little more than a century ago might have viewed the post-Reconstruction urban South as offering promise or peril; as being best served by looking forward or by maintaining supposed traditions; as either standing poised to embrace the liberal democratic ideals of progress or in danger of degenerating into utter disorder and conflict. Such variance in opinion, of course, is not limited to historical actors but also extends to those who have studied them. Indeed, even to use the term “post-Reconstruction” is to signal not merely an assumed periodization but also a certain set of beliefs about politics and geography. Some of the period’s ultimate resolutions, highlighted in the rise of segregation, disfranchisement, and racial violence, have led some scholars to refer to the period as one of “racial despair” (Claudia Tate), the “nadir of race relations” (Rayford Logan), a time of “African-American cultural grief” (Carolivia Herron), or an era of a “rage for order” (Joel Williamson). At the same time, post-Reconstruction urban southerners’ visions of promise, forward-looking progress, and democratic idealism often placed the region firmly within the zeitgeist of the Progressive era, whose attitudes were no more contained to the northeastern United States than race and labor conflict were maintained solely within the South.⁹

This book was not written under the presentist assumption that the history of tuberculosis in the early twentieth century should have explicit lessons for the global pandemic of tuberculosis in the early twenty-first century. Indeed, most historians of the subject likewise have been hesitant to make such a claim, and for very good reasons. Tuberculosis today is certainly a major public health problem (killing roughly two million people globally each year), along with other emerging infectious diseases, posing the possibility that the past six decades of antibiotic therapy have been but a brief respite in the millennia-old tyranny of the germ. Nonetheless, tuberculosis now involves an almost entirely different set of epidemiological questions and is no longer a primary cause of death among urban U.S. blacks. This is largely because of the introduction of chemotherapeutic interventions after

the late 1940s, the delivery of which became the bulk of tuberculosis control efforts by 1960. The successes of these efforts led to a scaling back of prevention, which, along with the twin crises of drug-resistant tuberculosis and HIV/AIDS, contributed to the reemergence of tuberculosis in the last decade of the twentieth century. Framing all of this, the political economy of the disease has much different configurations today as well. In the early twentieth century, the social and demographic profile of tuberculosis consisted largely of the urban poor, particularly those who suffered deleterious housing and working conditions. Overcrowding remains a very important factor in transmission (perhaps even more than it was a century ago), but today the bulk of tuberculosis incidence in the United States is concentrated among immigrants from countries in which tuberculosis is poorly controlled or who have been vulnerable to the infection after their arrival in the United States, the growing incarcerated population, intravenous drug users, those with compromised immune systems, and biologically vulnerable homeless or transient populations.¹⁰

In paying real attention to the political economy and social geography of Jim Crow and public health, this book takes an approach different from previous social histories of tuberculosis in the United States.¹¹ As such it also lies within a continuing historiographical engagement between the “post-Reconstruction” and “Progressive” eras, taking the emergence of modern urban public health in the South as a site wherein political leadership, medical expertise, and ordinary citizens negotiated the tensions between promise and peril, idealism and threat. In the United States, at the heart of the politics of what came to be called “phthisophobia” or “tuberculophobia” were many of the same anxieties of social distance and political impotence that also occasioned the emergence of Jim Crow in the South and nativism in the North and West. In allowing blacks and the political economy of Jim Crow to take an analytical place alongside health officials and policymakers, *Infectious Fear* argues that a consideration of organized black public health must be particularly expansive if for no other reason than that for much of the early twentieth century, blacks were excluded from or only slightly represented within organized professional public health and medicine. African Americans’ professional and extraprofessional perspectives (emerging from black physicians and nurses as well as from reformers, social workers, educators, and clergy) allowed them to link a variety of social and political problems to health in ways not normally contemplated by white professionals.

The reasons for using Baltimore as a case study are several. The size and character of Baltimore’s African American population were unique. In the

antebellum era, as Barbara Jeanne Fields has noted, Maryland existed on the middle ground between slave and free societies, maintaining within a wide range of slave and free existences.¹² Having demurred on invitations to join the Confederacy and therefore exempt from the Emancipation Proclamation of 1863, Maryland enacted emancipation on its own by constitutional referendum in November 1864. By this time, however, more than half of the state's roughly two hundred thousand blacks lived in freedom, a demographic balance unique to Maryland and amplified in Baltimore: less than one-tenth of the city's black population found its legal status changed by emancipation; the other 90 percent had begun to stake out a position in free society well before.¹³ Over the next thirty years, Baltimore emerged as an even greater attraction to free blacks and thousands of whites whose migration tested every resource the city possessed and left the state's rural white landowners complaining of labor shortages.¹⁴ Sympathetic to those landed interests, the Maryland Bureau of Industrial Statistics concluded in 1904 that black Baltimoreans, "unless properly directed industrially and educationally, will prove a menace in many respects."¹⁵

In the late nineteenth and early twentieth centuries, Baltimore and Maryland were demographically singular. In 1890, 36 percent of Maryland's black population was urban, more than twice the proportion of the South (15 percent) yet half that for the North (62 percent). Maryland's only major city had a smaller black population (16 percent) than other southern cities (32 percent) at the turn of the century. Largely through migration, between 1880 and 1900 the city's black population grew from 54,000 to 79,000 (47 percent), the second-highest numerical increase (behind Washington, D.C.) in the region between 1880 and 1890. Over the same period, however, the growth of the white population, native-born and immigrant (Polish, Lithuanians, Russian Jews, Greeks, and Romanians who formed communities largely in East Baltimore), was 54 percent, a greater numeric and proportional increase. Baltimore consequently experienced a 100 percent population increase between 1870 and 1900, entering the twentieth century as the nation's sixth-largest city, with more than 500,000 residents. Although the black proportion of the city's population shrank over these years (from 16.17 percent in 1880 to 15.60 percent in 1890 to 14.42 percent in 1900), Baltimore emerged as one of the nation's black capitals. In 1910, Baltimore had an African American population of more than 84,000, a claim surpassed only by Washington, D.C. (94,000), New York City (91,000), and New Orleans (89,000) and tied by Philadelphia. By the end of the First World War, Baltimore joined New York City, Chicago, Washington, and New Or-

leans as American cities with African American populations greater than 100,000.¹⁶ Meanwhile, Baltimore trailed only Manhattan and Brooklyn, New York, and Newark and Jersey City, New Jersey, in that order, in population density among U.S. cities with populations higher than 100,000. Of the ten most-dense cities in that class in the mid-1920s, Baltimore had the highest death rate by far (193 per 10,000 population, outdistancing the second-highest by 24).¹⁷

Certain aspects of Baltimore's economic and political life were also important. Between 1856 and 1900, for example, thirty-one black newspapers were established in Baltimore, underscoring both the communal capital that could be mustered and the low rate of total illiteracy among black Baltimoreans (fewer than 17 percent could neither read nor write in 1904, much lower than the South Atlantic region's 1910 rate of 47.1 percent). The *Baltimore Ledger* and *Afro-American*, both weekly publications, were the most widely read organs of the community, and, like the *Chicago Defender*, the *Pittsburgh Courier*, and the *New York Age*, carried national and international news while enjoying a national readership.¹⁸ Maryland's ratification of the Fifteenth Amendment in 1870 added some 39,000 voters to the nearly 131,000 whites registered in the state. Although the strength of the Republican Party in the state and in Baltimore owed much to black activity, after the years of militancy in the 1870s, the party was decreasingly disposed to reward such activity with substantial patronage. As Kevin Gaines has noted, the increasing assaults on black Americans at the turn of the century produced within black politics "a retreat from the earlier, unconditional claims black and white abolitionists made for emancipation, citizenship, and education based on Christian and Enlightenment ethics" and a "move from anti-slavery appeals for inalienable rights to more limited claims for black citizenship that required that the race demonstrate its preparedness to exercise those rights."¹⁹ Amid this decline, it was fortunate that enough of the city's sizable European immigrant population feared disfranchisement to join black Marylanders in fending off no fewer than three proposed "voting reform" (disfranchisement) amendments between 1903 and 1911, even as the immigrants competed with blacks for jobs and housing.²⁰

Chapter 1 offers some notes toward a historical epidemiology of tuberculosis, emphasizing that the timing and intensity of black populations' exposures to the bacillus and their changed interactions with environment likely account for shifts in mortality and morbidity. Throughout much of the period between 1850 and 1950, however, researchers investigated tuberculosis under the immense weight of the political and intellectual history of

TABLE I-1. Population of Afro-Baltimoreans, 1900–1940

Year	Nonwhite Population	Percentage of City Total	Percentage Increase over Past Decade	
			BLACK	WHITE
1880	53,703	16.2		
1890	71,033	15.6	32.3	15.7
1900	79,258	15.6	18.2	16.9
1910	84,749	15.2	6.9	10.2
1920	108,322	14.8	27.8	32.0
1930	142,706	17.7	31.7	5.9
1940	166,567	19.4	16.7	4.5

Source: Baltimore City Health Department Annual Reports

racial science. Chapter 2 discusses racial science in the context of tuberculosis epidemiology and politics during this period, arguing that the urbanization of blacks shaped this body of thought as much as it did scientific inquiry. Despite the protests of African American intellectual and medical leaders, white physicians, economists, and statisticians before 1920 expressed mainly negative views of the relationships among racial heritage, urbanization, and tuberculosis. Many viewed tuberculosis as the wage of the race’s unwholesome desire to flee the rural agricultural rhythms that were best suited for Negro physiology and intellect. In the context of tuberculosis research, mainstream public health’s gradual abandonment of strict racialism owed itself as much to demographic and political shifts as to technological and theoretical advancements.

Whereas chapter 2 argues that the politics of black labor and protest influenced the development of medical theory, chapter 3 describes the “Landscape of Health” as the material terrain that produces health conditions and as the social relations in space that actors of all kinds interpret to form explanations of illness and health. Rapid industrialization in the late nineteenth century produced the growth, differentiation, densities, and health fortunes of populations in space, which in turn became the lens through which health officials, political actors, and even patients perceived the relationship of health to “race.” This is not simply a matter of setting the political economic stage for the real work of doing public health history, for putting place at the fore of analysis produces a radical rethinking of tuberculosis history in the African American context. As a matter of perspective, an

examination of the growth of urban space and racial ghettoization in late-nineteenth-century Baltimore through the flawed official responses to both tuberculosis and housing shortages in the 1930s and 1940s incorporates a periodization that gives emphasis to the recognized roots of early-twentieth-century tuberculosis: inadequate housing and socioeconomic inequality. These were not randomly occurring or natural conditions, as “rational market conditions” were not easily separable from the “irrational vicissitudes of Jim Crow.” (One could easily argue the irrationality of markets or the economic utility of segregation in labor and housing.) It is here where readers searching for the “usable past” of tuberculosis will be most satisfied. Even as tuberculosis has receded as a prominent cause of mortality among North American blacks, contemporary public health researchers have shown us that continuing segregation and inequality remain as major root, or “fundamental,” causes of poor health. As Dolores Acevedo-Garcia has observed, residential segregation “may play a direct role, i.e. it may influence the probability of contact (transmission) [of infectious disease] *across* and *within* racial/ethnic groups.”²¹ Nor are these effects limited to infections, extending, as the growing literature makes clear, to the nutritional, environmental, and psychological.²²

Baltimore’s engagements with public health practice as well as its problems of ethnic tensions, housing, and labor reflected the city’s unique position at the time. Historian Rhonda Y. Williams has referred to twentieth-century Baltimore as a “border city” that brought “together southern racial traditions and northern urban-industrial economies.”²³ One result of this mixture was very high rates of tubercular mortality, reflecting the collision of an industrializing economy and the persistence of preindustrial housing stock. Baltimore’s tuberculosis death rate of 239.1 per 100,000 population in 1893 was higher than Chicago’s and St. Louis’s, about as high as Brooklyn’s and Philadelphia’s, and significantly lower than Boston’s and New York’s. Over the next decade, however, Baltimore’s tuberculosis death rate fell by less than 2 points, leaving it higher than those of all of those cities except New York, which exceeded Baltimore by only 0.81 points. At the same time, an economy solidly based in industrial manufacturing, garment production, shipping and commerce, and some food processing conferred on Baltimore many of the features—especially a large-budget municipal government and a philanthropic class to initiate social programs—of northeastern urban progressivism. Baltimore’s health department is the nation’s oldest, founded in 1793 in response to the imminent threat of yellow fever from Philadelphia, but its modern history was inaugurated in 1875, when the City Health De-

partment (CHD) began systematically to collect mortality statistics through department-issued burial permits, the first of a series of mechanisms of surveillance. Nine years later, another ordinance required the registration of all births. In 1898, following Baltimore's lead, the Maryland General Assembly passed the state's first vital statistics law, and in 1906 Maryland was the first state with a large African American population to be admitted to the U.S. Death Registration Area, membership in which statisticians, physicians, and politicians viewed as a hallmark of rational progress and civic modernity.²⁴ Much of the impetus came from the activity centered at Johns Hopkins Hospital and from the influence of such national and local medical celebrities as William Welch, William Osler, and John S. Fulton. In 1897, Osler and Fulton helped to found the Maryland Public Health Association, a body directly responsible for bringing to the state and to Baltimore sustained exchange on matters such as the construction of a sanitary sewer system and the establishment of a city hospital for infectious diseases.

Baltimore joined Philadelphia, Boston, and New York City as centers for tuberculosis research and antituberculosis activity. In 1896, however, Baltimore became the nation's first city to pass a universal and compulsory tuberculosis-reporting ordinance. Soon after founding the Maryland Public Health Association, Osler and Welch founded the Laennec Society, the first U.S. professional society for the study of tuberculosis. The modern national antituberculosis movement in the United States may be said to have begun with Baltimore's 1904 Tuberculosis Exposition, which led to the formation of the National Association for the Study and Prevention of Tuberculosis (NASPT) and the Maryland Association for the Prevention and Relief of Tuberculosis (MAPRT). By 1910, Maryland ranked ninth in private and public spending per capita for antituberculosis efforts, behind the "sun cure" locales of New Mexico, Colorado, and Arizona and the more industrialized states of New York, Connecticut, Massachusetts, Pennsylvania, and Rhode Island. The next former slave state in spending was North Carolina, which ranked seventeenth.²⁵

The CHD, as chapter 2 notes, ardently joined Northeast-centered public health movements even as it found itself in the middle of the South's emerging class and color conflicts over resources, jobs, and housing. City leaders, including those charged with health preservation, often articulated elaborate and racist/nationalist rationales for its successes and failures. Baltimore health official Dr. William Lee Howard announced with urgency in 1903 that "the negro . . . , untrammelled and free from control, is rapidly showing atavistic [health and behavioral] tendencies," a fact "ignored

by those who would have the African brought into social relations with the white woman.”²⁶ Some twenty years later, his son, Assistant Health Commissioner William T. Howard, attributed the CHD’s vigor to its Anglo-Saxon intellectual heritage despite the yearly arrival to Baltimore of thousands of immigrants who “kept alive diseases that were dying out, or have imported a disease in more virulent type.”²⁷ Such racial romantic and xenophobic flourishes did not characterize the entirety of the CHD’s view of the race question, yet they serve as a point of departure for a description of the “landscape of health” in Baltimore, with particular emphasis on the dialectical relationship between the developing geography of segregation and uneven development on one hand and the development of modern, bacteriological public health on the other. The general neglect of sanitary and other services in Baltimore’s African American neighborhoods produced conditions that health officials interpreted as being rooted in racial characteristics, which in turn could serve as a rationale for continued neglect in some matters but elevated attention in others.

Chapter 3 turns to the specific circumstances under which ideas introduced in chapter 1 informed the early antituberculosis movement in Baltimore and the Northeast (particularly New York City and Philadelphia). German physician Robert Koch’s 1882 discovery of the tubercle bacillus was followed in the late 1880s by the introduction of Philadelphia physician Lawrence Flick’s theory of “house infection”—the idea that the bacillus is most virulent and easily transmitted within closed spaces. Flick’s theory met with entrenched opposition from private physicians, mainly because Flick was committed to state medicine and argued that house infection theory mandated the registration of all tuberculosis cases and their habitations, a requirement that threatened doctor-physician privacy. The theory of house infection might have militated against racialism, as Flick was adamant about the fundamental roles of environmental and socioeconomic factors in infection, but many private physicians argued that heredity, not infection, was the real problem and that surveillance, if at all adopted, should fall largely on the ethnic poor by virtue of their genetic inheritance and inability (or unwillingness) to seek private care. This debate was enacted throughout the United States, pitting adherents of public health and bacteriology against proponents of private medicine and the principles of heredity. Consequently, although most cities adopted universal notification, the specific terms were often class- and race-inflected in that white middle-class patients were not subject to household inspections and other intrusions. These measures, along with visiting nursing, dispensary work, and a massive educational

campaign, comprised the bulk of early antituberculosis work. Their effects are difficult to measure. The small improvement in tuberculosis mortality probably resulted more from general improvements in living conditions, but the efforts in case building and patient tracking served as the foundation of more mature epidemiology after 1920 even as they provided rationale for stigmatization and surveillance.

The political consequences were twofold. Contrary to Flick's original intent and the existing scientific evidence, the popularization of house infection theory was predicated largely on theories of racial predisposition and on social stereotypes mobilized to rally support for new antituberculosis measures, including mandatory registration. Stigma, in Erving Goffman's formulation, serves to signify lack of social acceptance due to the danger of deviance from prescribed norms. In this dynamic, visibility or perceptibility is crucial for establishment and "cognitive recognition"—the "act of 'placing' an individual" with a specific social or personal identity, aspects also elaborated, for example, in Talcott Parsons's sociological theory of the "sick role" and in Mary Douglas's anthropological theories of risk, purity, and danger.²⁸ Yet the symptoms of tuberculosis were easily hidden from view, particularly during brief and impersonal encounters, and in the absence of visible certainty, middle-class whites could anxiously insert the probabilism of skin color to make blackness itself, as David McBride has remarked, "an icon for contagion and susceptibility," leaving blacks particularly vulnerable to regimes of surveillance.²⁹ The second, related, consequence was that continued neglect of black welfare more generally impelled a separate organic movement among blacks to form their own networks and institutions of health improvement whose material effects are likewise difficult to assess but that formed the institutional bases for the entry of black professionals into public health. Particularly in the early antituberculosis movement (before 1920), the rejection of stigma, the indictment of neglect, and ideals of community self-help and care were the galvanizing issues of black public health work.

Whereas chapter 2 describes the relationship between built environment and uneven development, chapter 4 returns to the theme of political and economic geography, describing the "lung block" as the cartographical expression of the compromises explained in chapter 3. By 1901, Baltimore's Lower Druid Hill neighborhood variously could connote an area of intense tuberculosis mortality, a place from which tuberculosis might spread to other parts of the city, an area whose rampant vice was a causal factor in the development of tuberculosis, and a place whose neglect at the hands of police and public health produced both vice and disease. Although this chapter is

concerned very much with the production and interpretation of maps, cartography is taken broadly as part of the social imagination, a representational act in which intellectual and political context is important. This chapter therefore examines the development of public health cartography as well as its relationship within the early antituberculosis movement to the social survey, social photography, contestations launched by blacks from outside public health, and the proliferation of the lung block imaginary in other U.S. cities. In describing the failure of housing reform in black neighborhoods and the eventual destruction of Lower Druid Hill, chapter 4 also foreshadows one of the conclusions of this book: that the era of slum clearance, public housing construction, and urban renewal mark the endpoint of the history of early-twentieth-century African American tuberculosis more appropriately than the advent of antimicrobial therapies in the 1940s and 1950s.

Of course, a language of risk imbued most discussions of tubercular infection, emphasizing not only racial predisposition or social contact but also an extensive catalog of behaviors and circumstances.³⁰ Chapter 5 describes the emergence of the specter of the “incurable consumptive,” a sick role foisted on most poor and all black consumptives, with implications for the development of a two-tiered system of care in Baltimore. Care was inseparable from surveillance, and health officials, especially visiting nurses, made it clear that the benefits of the dispensary system were twofold: it offered help to the ill while providing the institutional structure for data collection and the monitoring of patients who seemed willfully to elude supervision. This chapter also chronicles the development of African American social work in Baltimore, leading to community agitation for the hiring of black visiting nurses and physicians within the CHD in the early 1920s.

Although CHD officials described black professional incorporation as an experiment and black community interest in public health as novel, the lowering of the color bar had more to do with the realpolitik understanding that black professionals were in better positions to surveil black patients. The same holds true, chapter 6 argues, for the establishment of Maryland’s first sanatorium for African Americans, Henryton Sanatorium, in 1923. The campaign to open the sanatorium, which began in 1915, had not been among blacks’ immediate political or health concerns, largely because it was based more in appeals to white interests in incarcerating black “incurables” than in real treatment. This was a reason to be suspicious of the campaign, as was the State Assembly’s decision to make Henryton color exclusive even while informed opinion argued that color-inclusive (though internally segregated) facilities would prove more effective than a single institution for blacks.

Historians generally agree that as public health measures, sanatoriums in general probably effected little improvement before the 1940s, when their focus shifted to chemical therapies and by which time pneumothoracic (lung collapse) surgery had become more promising. Although few of Henryton's records survive, little more could have been expected of it, since its administrators admitted a disproportionately high number of patients with advanced disease who stood little chance of recovery, while its inadequate number of beds left many advanced cases to spread the disease in overcrowded housing. In addition, the institution's political failures included documented cases of patient abuse.

Black leaders understood the Henryton campaign to be a distraction from the root cause of the tuberculosis problem, poorly maintained and increasingly scarce housing under segregation and population growth. Throughout the 1910s, black physicians and other leaders were more visible in their agitation for improved housing than in support for a black sanatorium. Chapter 7 discusses the increasing friction between black and white leaders in the matter of housing, even as certain aspects of public health (such as the National Negro Health Week movement) seemed to be grounds for black and white cooperation. (Cooperationism and segregationism were not mutually exclusive.) In the 1930s and 1940s, Baltimore earmarked growing funds for black community health programs (by then run largely by black professionals), while the CHD cemented its role in designating areas for slum clearance (maps of tuberculosis incidence and mortality would again reappear, but in conjunction with those revealing incidence of syphilis), placing the department in the problematic role of guarding against one of the effects of residential segregation even as it helped to create Baltimore's second ghetto.

This introduction began with the caveat that the history of race and tuberculosis should not be taken as having immediate lessons specifically for the tuberculosis crisis today. The book, however, offers more fundamental observations. As "new" immigrants arrive in the United States (a demographic shift that is not unique to this country), we must ask new questions, questions not asked a century ago, to understand the historical connections between class and racial formation, biopolitical contests regarding citizenship rights (the pitiable sick versus the incorrigibly unhygienic), and the concrete (geographic, economic, historical) processes of statecraft, surveillance, and bureaucratic expansion that public health automatically implies. This is not insignificant, for clues to future solutions may be found in past failures.³¹