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Despite its expansive title, this book is a case study of tuberculosis among African Americans living in Baltimore in the first decades of the twentieth century. Samuel Kelton Roberts, Jr. emphasizes the connection between health effects of segregation then (tuberculosis) and later, when the influence of ghettos played out in social as well as physical pathologies. Segregation is, he concludes, “a fundamental cause of illness, even if historians of Jim Crow have not included health deficits in full accounts of the wages of segregation” (p. 221). Roberts demonstrates that the evils perpetrated by the restriction of blacks to a few slum areas, beginning during Reconstruction but burgeoning after 1900, bred overcrowding, inadequate sanitation, and the emergence of “lung blocks,” neighborhoods so infested with tuberculosis that public health officials identified them by name.

Roberts begins his study by documenting in exhaustive detail the high prevalence of tuberculosis among African Americans living in urban areas from the 1870s, a prevalence that began to decline only in the 1920s. The reasons for the emergence of tuberculosis as an African American health problem in this era are not obscure: former slaves rushed to urban areas seeking work and an escape from agriculture only to find poverty and crowded housing. Tuberculosis flamed among this malnourished population living in dark, poorly ventilated slum dwellings. Roberts is less clear on why tuberculosis began to decline in the 1920s. While he depicts public health efforts as largely futile, Roberts offers little else to explain the change. With the advent of effective antibiotics in the 1940s and 1950s, the disease diminished rapidly in Baltimore as it did elsewhere.

This emergence of tuberculosis did not go unnoticed by contemporaries. The earliest response was to blame heredity and racial constitution, coupled with the degenerate behavior of the African race. Even after the germ theory of tuberculosis took hold in the 1880s, physicians argued that some people were more susceptible than others. As tuberculosis had never been common among plantation slaves, its appearance among Jim Crow blacks in urban areas led to easy conclusions that slavery had promoted black health and that freedom was inimical to it.

These sorts of arguments took on new life in the second and third decades of the twentieth century when Baltimore launched public health campaigns against tuberculosis that utilized visiting nurses to identify and remedy the infection. These women sought to teach their clients to dispose of sputum in a sanitary fashion, to sleep with their windows open, and otherwise to live sanitary lives. Although many of the poor were difficult customers, it was the black patient who was most likely to be labeled “incorrigible” (p. 148), the kind of patient who disobeyed orders, disappeared from surveillance, and otherwise resisted the control of health authorities.

The only therapeutic intervention available in this era was the sanatorium, a specialty hospital for tuberculosis patients that was usually placed in a country setting where fresh air and sunshine were available in abundance. Patients who could rest and eat enough had a chance to fight off their infection. While the number of U.S. sanatoriums exploded between 1895 (19) and 1920 (435), very few beds were open to black patients. During the 1920s, as the fear of the tubercular black servant grew, governments increasingly recognized the need to isolate the dangerous black tuberculosis patient in order to control infection. While white patients were admitted to the sanatorium during the early stages of illness in order to treat the disease, most black patients were admitted late, with the specific intention of quarantining the infectious source.

Thus when Maryland finally opened a black sanatorium in 1923, it followed this model. Patients were inmates and not allowed to leave without the permission of the superintendent. The institution was twenty-five miles from Baltimore, without access to public transportation, and was shunned by black patients who would rather die at home than be subjected to its foul meals, harsh environment, and distance from their families. Black professionals pushed for reform, especially in the staffing of these hospitals with black doctors and nurses. There was some improvement in the sanatorium overtime, including the integration of its staff, but it remained a substandard institution.

This book expands our understanding of the encounter between public health professionals and the poor, and it opens the door to further scholarship on the ways in which public health action was determined by racial as opposed to class lines. Roberts acknowledges that there were other stigmatized tuberculosis patients in Baltimore, especially recent immigrants. One might also question the extent to which Baltimore is a truly representative “southern” city, and the ways these questions played out in the urban areas of the deeper South. This book is a solid contribution to research on health disparities, a field that needs to do much more to acknowledge that such disparities have deep historical roots that require excavation.

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In some ways, Janet G. Hudson’s study of South Carolina in the decade beginning with World War I can be seen as a working out of C. Vann Woodward’s shorthand formula for reform in the American South: “progressivism—for whites only.” The core of Hudson’s argument is that while World War I initiated a number of