

Chapter Four

“Where Our Melanotic Citizens Predominate”: Locating African Americans And Finding Baltimore's Lung Block

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Of course, we cannot assume that there is any unfortunate who arises in the morning from a bed whose linen was washed by a tuberculous laundress and goes down to a breakfast delivered at his back door by a tuberculous negro boy, prepared by a tuberculous cook, and served by a tuberculous maid, then repairs to his office cleaned (?) by a tuberculous scrubwoman, and later mops his fevered brow with a handkerchief laundered by the same tuberculous laundress, and perhaps lunches at a hotel where a tuberculous cook and waiter serve him! . . . But has it not a very serious side?

Truman A. Parker,

“The Negro as a Factor in the Spread of Tuberculosis,” Virginia

Medical Semi-Monthly, 8 October 1909

The structure of organized space is not a separate structure with its own autonomous laws of construction and transformation, nor is it simply an expression of the class structure emerging from social (and thus aspatial?) relations of production. It represents, instead, a dialectically defined component of the general relations of production, relations which are simultaneously social and spatial.

Edward Soja, Postmodern Geographies: The Reassertion of Space
in Critical Social Theory (1989), 78

Chapters Two and Four argued that there was no understanding tuberculosis in the nineteenth century outside of the frame of class relations that were in turn understood as racial. My discussion of house infection in the previous chapter illustrated this to be the case even after the discovery of the bacillus: what most historians of public health have missed is that the politics of house infection was never a matter of “pure theory,” devoid of class politics that were often expressed as racial. To make the theory’s implications more palatable, its proponents assented to certain compromises that thereafter ensured that health workers would emphasize facets that were supposedly biologically (or “racially”), or socially (or “pathologically”) hereditary, but really pertained more to class.

After the political and theoretical compromises of the 1890s, proponents of house infection theory gained support for their views through the subsequent publication of studies in

the United States, Britain, and Europe. As a result, health officials found themselves revisiting older ideas about disease. House infection was the result of bacteriological theory, but, as Anne Hardy has shown, it also gave rise to a neo-miasmatic way of thinking about “epidemic streets.” By the 1890s, physicians generally referred to an urban geography of disease as being simultaneously an expression and a cause of illness.¹ **[INSERT HERE EITHER A BRIEF DISCUSSION OF THE RISE OF HOUSE INFECTION OR A LONG FOOTNOTE].**

The question therefore remains: what were the implications of house infection for the creation of a public health campaign conducted in this new urban terrain? In answer, I argue in this chapter that the theory of house infection was the primary vehicle by which health workers presented information about tuberculosis prevention to the public. The ascendancy of house infection signaled a new way of thinking about the disease, but it also provided a way of representing tuberculosis in a campaign that early on adopted the tenets of public education and advertising. Without an effective and widely-applicable treatment of the disease (let alone a cure), health personnel agreed that the public had to be convinced of the necessity and civic responsibility of prophylaxis. The turn-of-the-century American city was, of course, a spatial articulation of rapidly changing networks of capital and social relations, and the geographic distribution of disease was very much a product of this spatial articulation – this was the argument of the first chapter. In this chapter I argue that health workers’ public presentation of house infection constituted a reification of certain class relations through an ideology of race and space. There was something about an airborne bacillus that thrived in enclosed spaces that seemed to provide a mandate for the surveillance of the black domestic sphere in the name of

¹ Anne Hardy, *The Epidemic Streets: Infectious Disease and the Rise of Preventive Medicine, 1856-1900*, Oxford: Clarendon Press, 1993, 240-45.

protecting the white domestic sphere, or more specifically, for ensuring that employers of domestic labor could assert added control. The surveillance aspect is discussed in the next chapter. This chapter outlines the contours of the “discovery” of Baltimore’s “Lung Block,” the geographic sign for black tuberculosis and cross-color contagion.

Maps, of course, were important in promoting this reification, and the mapping of death necessarily privileged space over time in that it rendered illness static, something to be represented as a geometric point or dot on a grid. By representing the end result of illness (death) the spot map was entirely ineffective to convey the social processes that created the geographic distribution of health disparities, processes that led to death -- no apparent causal relation through the process of urban underdevelopment described in Chapter One would have been apparent between the inequality that produced the ill terrain of poverty and the fear felt by residents of Baltimore’s more affluent neighborhoods. Disease was to be represented as a matter of space that was at once disconnected (discrete ethnic enclaves or ghettos) and connected (through commercial interdependence).

The dynamic I describe therefore had a dramaturgical element to it.² There had to be a discovery of the problem, house infection. Sensational investigation and public revelation followed – the housing survey, the map, the photograph, the exposition. These were representational technologies that were also epistemological in that they constituted methods by which social scientists and health workers produced knowledge of the disease. The social survey, begun in England and quickly imported to the United States, enjoyed a half-century

² On the dramaturgical aspects of social response to disease, especially epidemics, see Charles Rosenberg, “What is an Epidemic? AIDS in Historical Perspective,” in *Explaining Epidemics and Other Studies in the History of Medicine*, New York: Cambridge University Press, 1992.

genealogy by 1900, when it was specifically applied to housing conditions and tuberculosis.³

The housing survey of the late nineteenth century had all of the social survey's signature features: graphic description (the housing surveyor was a more engaged and analytical flaneur); categorization offered with the veneer of the rigid science; and maps that purportedly served as objective evidence supporting an epidemiological explanation. The same was true of the tuberculosis exposition, as I discuss later in this chapter. By constructing a tuberculosis exposition (Baltimore held the nation's first in 1904), one could reach mass audiences by offering the *experience* of knowledge, a ritual whose cultural importance had been established by the World Exposition movement.⁴ The tuberculosis exposition's design was meant to impart a sense of empowerment through the gaze, and many of its exhibits emphasized the interiority of the body and the home (and the connections between), providing a view not ordinarily enjoyed by the average person. This experience was then carried over in the proliferation of the map. Uniting all of these technologies, transporting meaning from one to another (one may decipher a map or a table more easily when it is juxtaposed immediately or semiotically with an image), was the photograph, which I discuss in the next chapter.

The geographical icon of this stigma was the "Lung Block," the discovery of which was the first act in the drama of tuberculosis control. Yet Lung Blocks were more "created" as part of the public health imagination than truly discovered. As areas of high mortality they were not altogether unknown to suspecting health workers and these areas tended to be known to the

³ See Martin Bulmer, Kevin Bales, and Kathryn Kish Sklar, "The social survey in historical perspective," in The social survey in historical perspective, 1880-1940, Bulmer, Bales and Sklar, eds.. New York: Cambridge University Press, 1991, 1-48; and Bulmer, "The decline of the Social Survey Movement and the rise of American empirical sociology," *ibid.*, 291-315.

⁴ Robert W. Rydell, All the World's a Fair: Visions of Empire at the American International Expositions, 1876-1916, Chicago: University of Chicago Press, 1984.

public already as areas of poverty and vice, yet by framing the identification of the Lung Block in a language of discovery, physicians could implicitly make claims concerning their authority over space or, at least, its representations and study. To map an area is to claim that it was, prior to the cartographic moment, in some way unknown, often at the cost of those who exist in the terrain to be discovered, examined, and eventually acted upon.⁵ That public health officials could identify these neighborhoods as sites of infection (and as sources of contagion) endowed them with the power to prescribe public policy measures regarding these areas, and enforced a popular representation of racial ghettos as places of chaos, disorder, and social and physical breakdown. It is “the map that precedes the territory”, as Baudrillard observed, not the other way around, a point made clear by social investigator Ernest Poole in his photographic essay on New York's Lung Block (which also included a map): “I use this one block as a center; not to prove, but to image what has already been proved all through the civilized world, to image the three great evils we must fight in the tenement. . . congestion, dissipation, infection.”⁶ The Lung Block was essentially the manifestation of a pre-determined natural law: the spiraling decline of dissipation and disease; and in reimagining the space of race as the space of illness, what health

⁵ James Duncan, “Sites of Representation: Place, Time and the Discourse of the Other,” in James Duncan and David Ley, eds., Place/Culture/Representation, New York: Routledge, 1993; Geoff King, “The Imperialist Map: Beyond Materialism and Idealism”, in Mapping Reality: An Exploration of Cultural Cartographies, New York: St. Martin's Press, 1996.

⁶ Ernest Poole, “The Lung Block: Some Pictures of Consumption in Its Stronghold,” Charities 11 (5 September 1903), 193. Jean Baudrillard, Simulations, 1981, trans. Paul Foss, Paul Patton, and Philip Beitchman, New York, 1983, 2. To represent an area as wilderness, for example, is to signal that the peoples who actually have lived there for hundreds of years will soon be subjected to colonial rule, providing the answer the question for which the map was commissioned in the first place: can this land be viably colonized? “It was the act of wholesale alienation and appropriation,” Geoff King notes, “that made the colonial mapping. . . so effective a tool. The map served both to fix and to segment the territory; to control it, to make claims of sovereignty and to package it for sale. . . . The Western colonial map is an abstraction that tends to extinguish other dimensions of reality in an act of violent appropriation” (King, 1996, 144-45). Though he does not discuss the micropolitics of colonial cartography, Philip Curtin offers a brief analysis of the political meaning of mapmaking in the colonial context. See Curtin, The World and the West: The European Challenge and the Overseas Response in the Age of Empire, New York: Cambridge University Press, 2000, 4, 12-17.

officials performed was the mapping of disease upon the map of race in New York, Baltimore, and other cities. Public health workers from across the nation, particularly the South, who viewed Baltimore's tuberculosis exhibitions to compare their city's tuberculosis problem with Baltimore's were implicitly advised to seek out the Lung Block in their own communities.

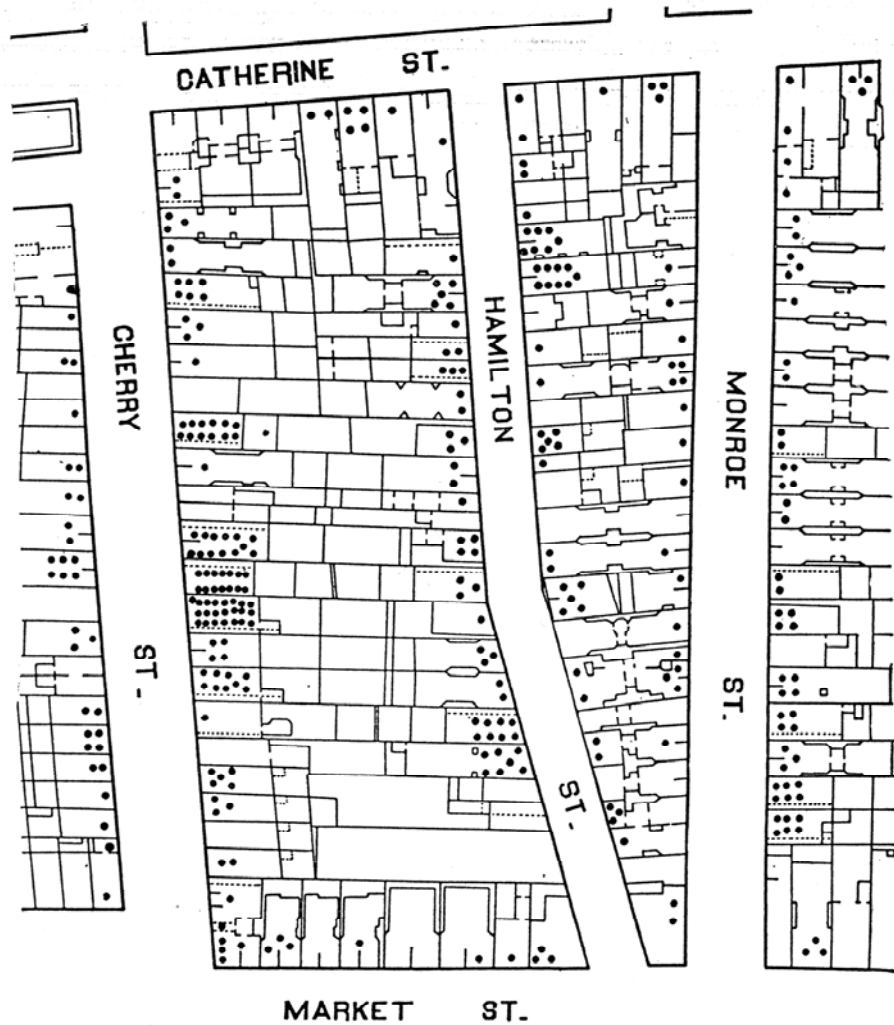


Figure 1: “It is here, among the crowded poor, that this Plague [tuberculosis] feeds fat on ignorance and poverty.” (Poole 1903). New York City’s “Lung Block,” a multi-ethnic eastern and southern European enclave, was bounded by Cherry, Catherine, Hamilton, and Market Streets. This map was reproduced from sectional maps composed by Hermann Biggs of the City Department of Health, and published in articles by Biggs, Ernest

Poole, and others. The dots represent tuberculosis deaths occurring between 1894-1898 (lots with no dots are warehouses).

In regard to black tuberculosis, the technology of mapping disease mortality was the signal shorthand for the knowledge of space produced by health workers -- it promoted the demarcation of spaces of health and illness that were at once thought to be largely coterminous with those of color. In particular this chapter will address four studies that emerged in Baltimore since the rise of house infection in the 1890s but before housing reform in 1908. Adelaide Dutcher's brief and unfunded study of downtown Baltimore in 1900 marked the beginning of studies motivated by house infection theory. The simultaneous production of tuberculosis mortality maps of the entire city later allowed health officials to talk of spaces of racial and disease concentration – the Biddle Alley district in Lower Druid Hill, an area that officials named the “Lung Block.” The Tuberculosis Exposition of 1904 further emphasized this point. A second survey, the citywide Police Health Census of 1906, set the tone for further study of the city by describing black disease and black neighborhoods as an object of study different from white subjects. Perhaps more informed by emerging social science precepts than any that had come before, the third survey, Janet Kemp's housing survey of 1907 carried the political and social capital of Baltimore's two largest charity organizations, which funded and promoted the survey. Kemp focused on the Biddle Alley District and through methodological lapses established black poverty and disease as somehow different from their manifestations among whites. In 1908, the year of housing reform, the Colored Law and Order League attempted to point out what Kemp and others had missed, that black tuberculosis, particularly in Lower Druid Hill, was political. For them, the representative black men of the city, the political connoted law

and order, a typically masculine way of doing politics in the early twentieth-century United States.

The utility of the survey and the spot map lay in their effectiveness in bolstering a narrative that implied that the surrender of privacy through surveillance would ultimately promise the benefit of the effective policing of those not willing or able to police themselves. In a lecture before Philadelphia physicians, the New York City Health Department's chief bacteriologist, Dr. Hermann Biggs, defended his city's 1897 universal compulsory notification ordinance on the basis that it "would be undemocratic, and probably illegal, to require the reporting of cases living under certain conditions, as in tenements, and to exclude those living under other conditions, as in private houses," but frankly admitted that the Department "has not endeavored to enforce strictly the regulations" and even encouraged physicians and health officials to "use their discretion in regard to the measures which shall be adopted under varying conditions, depending upon the danger which they conceive exists as far as the public is concerned." This was a concession to physicians in the United States and in Britain critical of universal reporting, and three maps (of Biggs's construction) of areas of high tuberculosis mortality in New York (one of the Lung Block) showed his audience who the real objects of surveillance and even incarceration were: the largely southern and eastern European immigrants of the tenements.⁷

In the South, blacks were especially vulnerable to such uses of geography. The Progressive era in the South was coincident with the "nadir of race relations," an era of extreme ethnic policing that generally excluded blacks, particularly women, from various aspects of the

⁷ Biggs, "The Registration of Tuberculosis" Philadelphia Medical Journal 6:22 (1 December 1900), 1023-29.

public sphere. Through a dense architecture of policing and circumscription, blacks could make only a difficult entry into electoral politics, an open housing market, certain public spaces, and industrial participation and organization. They were generally restricted to work and live in spaces that were vulnerable to white-dominated institutions and stigma. After describing the establishment of the conceptual geography of disease and race in Baltimore in this chapter, in the following one I move on to describe the ensuing policies that promised benefit to blacks and racial management to whites.

“WHERE THE DANGER LIES IN TUBERCULOSIS”: THE GEOGRAPHIC IMAGINATION

Along with Biggs's defense of mandatory reporting, the 1 December 1900 issue of the Philadelphia Medical Journal included another article highlighting the geography of tuberculosis. One of Baltimore's earliest tuberculosis surveys, published as “Where the Danger Lies in Tuberculosis,” was produced by Adelaide Dutcher, a Johns Hopkins medical student. Dutcher worked in the innovative home visitation program begun by William Osler, and her report was the first of several publications that would come out of that program over the next two decades. Osler in the 1890s had become an ardent and vocal convert to the theory of house infection, and was also a co-founder of the earliest American medical society dedicated to the study of pulmonary disease, the Laennec Society, which had commissioned Dutcher's study. Dutcher first presented her work before the Laennec Society in 1900, where she was introduced by Osler,

whose comments were also published, sandwiched between Biggs's and Dutcher's work in the Philadelphia Medical Journal, in a two-page article titled "On the Study of Tuberculosis."⁸

Dutcher, who had been assigned to work in only specific areas of the city, identified in Baltimore two neighborhoods in particular as having high tuberculosis incidence. Of the 190 outpatient cases assigned to her (hardly all of the consumptives in her territory), she found that eighty-five percent resided in an area within fifteen blocks of the hospital (in downtown Baltimore), extending southeasterly along the Baltimore harbor, or in another area between 60 and 120 square blocks surrounding the intersection of West Baltimore Street and South Charles Street. These two districts, representing the center city, contained some of Baltimore's oldest dwellings, housing "the greatest massing of the poor" — native whites, African Americans, and Russian Jewish immigrants.⁹

Implicit in Dutcher's reading of race into geography was the assumption that culture played an important role in determining the tuberculosis mortality within certain imagined borders. "According to their social and domestic conditions," Dutcher observed, her 190 patients "divide themselves naturally into blacks, whites, and Russians."¹⁰ To assess the disease threat of Russian immigrants, Afro-Baltimoreans, and native-born whites (the last of whom she described

⁸ The Laennec Society was formed in 1898 and officially organized in 1900 by William Osler and others connected with the Johns Hopkins Hospital. Shortly before the first meeting of the Laennec in 1898, Osler, a proponent of Flick's theory of house infection, had begun a program whereby tuberculosis patients were visited in their homes. In the belief that assessing and improving home conditions was an essential step toward alleviating the tuberculosis problem in Baltimore, Osler hoped to discover the conditions under which Baltimore's tuberculous lived while also advising them on how to improve their living situation. "If a well-informed and sympathetic person paid a visit to the house," Osler proposed, "[and] saw the conditions under which the patient lived, directions could be given with much more likelihood that they would be carried out. Valuable information could also be obtained as to the mode of living and surroundings of these people." See William Osler, "On the Study of Tuberculosis," Philadelphia Medical Journal, December 1, 1900, 1030.

⁹ Adelaide Dutcher, "Where the Danger Lies in Tuberculosis," The Philadelphia Medical Journal 6:22 (1 December 1900), 1030.

¹⁰ *Ibid*, 1030-31. Italics mine.

as “the most interesting and most hopeful class for the trial of our methods of prophylaxis”), Dutcher employed five categories (location, crowding, cleanliness, light, and ventilation) which she determined to be factors contributing to tuberculosis incidence. She then ranked each of the three ethnic groups in the threat they posed to the city.¹¹

SUMMARY OF TABULATION.

Total number of patients	190	}	Whites	130	
Number of houses occupied	234		Blacks	40	
			Russians.	20	
			RUSSIANS.	BLACKS.	WHITES.
Bad sanitary location	69%		40%	30%	
Insufficient light and ventilation	83%		71%	46%	
Overcrowding	76%		50%	46%	
Personal and household cleanliness	75%		66%	43%	

Adelaide Dutcher’s system of classifying her patients in downtown Baltimore. Dutcher, “Where the Danger Lies in Tuberculosis,” The Philadelphia Medical Journal 6:22 (1 December 1900), 1031.

Dutcher found in Baltimore’s Russian immigrant population, who were residentially “fairly well limited to a triangular area bounded by Monument Street, Central Avenue and Jones’ Falls,” some of the most “dangerous elements in our midst as breeders and spreaders of this disease.” Eighty-three percent of her Russian patients lived in residences with insufficient sunlight and air circulation, conditions recognized as particularly conducive to the spread of tuberculosis, since natural sunlight was then believed to kill the bacillus and proper ventilation reduced the risk of inhalation. Seventy-six percent lived in conditions characterized as “overcrowded.” Describing the general immediate surroundings of the household, Dutcher found sixty-nine percent to be living in “bad sanitary locations,” and seventy-five percent to be

¹¹ Ibid.

living in poor “personal and household cleanliness”, many “in filth sometimes absolutely beyond description.”¹² The cultural produced the physiological: most Russians in her district lived in conditions in which “their resistance to disease must naturally be lowered.” Along with their insalubrious environment, Russians were an increased threat, Dutcher alleged, because they simply could not be taught methods of care and prevention.¹³

Although Maryland's antituberculosis crusaders would later exhibit an almost singular fascination with the tuberculous Negro, in 1900 Dutcher ranked Baltimore's African-American population as “an intermediate class between the Russians and the rest of the whites,” in the danger they posed to the rest of the community.¹⁴ While sixty percent of the African Americans in her district had “at least fairly good locations” in housing, there was “a decided drop in the percentage of other elements that go to make up hygienic environment.” Seventy-one percent of her black patients lived with insufficient light and ventilation; fifty percent lived in conditions that she characterized as overcrowded. Sixty-six percent “are dirty,” an ambiguous statement that left the reader to wonder if the reference was to the patient or the environment. While Dutcher assessed the threat of the colored population in her district below that of the Russians, she was quick to comment on her African-American charges' habits of hygiene. “The colored

¹² Ibid, 1031.

¹³ Ibid., 1031, 1032. Dutcher's assessment of Russian Jews in Baltimore contrasts with Ernest Poole's undoubtedly exaggerated claim, that “hardly a case of consumption” could be found among the Jews living in New York's Lung Block. Poole, 1903, 193.

¹⁴ Similarly, William Osler (Dutcher's supervisor), was heartened by the fact that “the colored population” maintained a “desire to occupy their own houses, so that there is a [sic] comparatively little overcrowding.” The Russians, whom he identified as Jews (Dutcher did not), lived in what was once a wealthy white Protestant neighborhood that had been converted to tenements, often with a “family of seven or eight. . . found in two rooms.” The “contrast in the matter of personal and household cleanliness” between Russians and “the other whites” was striking. “It is exceptional,” he claimed, to find the former “in a condition, either in person or house, that could be termed in any way cleanly.” Osler, “The Home in its Relation to the Tuberculosis Problem,” *New York Medical News* 83:24 (12 December 1903), 1108.

people seem to be especially careless about smearing their sputum over their clothing,” Dutcher observed. Invoking the sartorial signifier of the domestic worker, and thus the spectre of the tuberculous Negro servant or laundress, Dutcher sounded the alarm: “While talking with them I have frequently had occasion to stop individuals from depositing their spit on the corner of an apron or some other garment worn.” Dutcher concluded with optimism born of an unwavering faith – characteristic of the very early antituberculosis movement but subsequently discarded in coming years -- in the tenets of house infection and public health policing. Although it was clear that certain “houses are becoming centers of infection,” she found that, reinforced by frequent visits, simple education (except in the case of Baltimore’s Russians) regarding the mode of infection and in methods of disinfection and quarantine was adequate to alter behavior.¹⁵

Despite Dutcher’s initial impression that it was the city’s Russian immigrants who posed the greatest challenge regarding hygienic education, it is apparent that throughout Maryland’s anti-tuberculosis campaign health officials regarded blacks as the primary threat to whites. This was largely because, being generally excluded from industrial labor, blacks were disproportionately relegated to service positions in which their proximity to whites was cause for concern.¹⁶ For the city’s black population, healthy or otherwise, the lines demarcating home and occupation, private sphere and public sphere, were unclear. Without forceful industrial or political advocacy, and disproportionately relegated to home or service occupations, black

¹⁵ Dutcher, 1900, 1031, 1032.

¹⁶ Even those that found industrial work were excluded from the city’s union locals, which, in Baltimore, served as workers’ advocates and cooperated with health officials to coordinate campaigns of social reform and health improvement. James Benedict Crooks, Politics and Progress: The Rise of Urban Progressivism in Baltimore, 1895 to 1911, Baton Rouge: Louisiana State University Press, 1968, 166.

Baltimoreans, especially women, would become singular targets for public health scrutiny rationalized by the “house infection” paradigm.

Thanks to a donation by “two ladies, interested in the disease,” in 1899 Dr. William Osler was able to expand the tuberculosis work of Hopkins Hospital and its tuberculosis dispensary. Because the former would never have enough beds to accommodate all the consumptives in need of care, the work of the latter tended toward the coordination of efforts to educate consumptives in their home in the methods of prevention. The dispensary, along with the work of IVNA nurses – principally Adelaide Dutcher, Elizabeth Blauvelt, and Esther Rosencrantz – also proved effective in data collection. Hopkins Dispensary served a population larger and more geographically diverse than the one administered by Dutcher in the very late nineteenth century. As a result of visits made to the dispensary, usually for simple diagnosis, by 1903 the three nurses had built up a case list of 726 cases, including 545 whites (including 53 Russian Jews) and 181 blacks. The remainder were unspecified. Using the taxonomies of ethnicity and housing conditions that Dutcher had initially used in 1899-1900, during visits following outpatient service the three nurses used similar methods to assess the living conditions of their charges.

¹⁷ Osler, “The Home in its Relation to the Tuberculosis Problem,” New York Medical News 83:24 (12 December 1903): 1107.

	Russian	Colored	White
Bad sanitary location.....	62%	53%	16%
Insufficient light and ventilation.....	71%	65%	39%
Overcrowding.....	61%	41%	32%
Personal and household uncleanness.	70%	56%	30%

Figure 2: Assessments made by visiting nurses in Baltimore, consequent of outpatient service at Hopkins Tuberculosis Dispensary. William Osler, "The Home in its Relation to the Tuberculosis Problem," New York Medical News 83:24 (12 December 1903), 1107.

Among white patients could be found the greatest geographic diversity, many of them living "on new streets in the suburbs." Only twenty percent could be said to be living in bad neighborhoods, mostly to the southwest of the Hospital, "where the houses are close together and hemmed in narrow alleys and courts" and where Dutcher continued her work. The African-American population tended to live in more unfavorable conditions, but, due to their "desire always to occupy their own houses" suffered less overcrowding than Russian Jews, who lived in tenements where "very often a family of seven or eight is found in two rooms." Osler repeated Dutcher's assessment of the Russians. It was "exceptional," to find them "in a condition, either in person or house, that could be termed in any way cleanly."

Published in the New York Medical News, Osler's recommendations were directed at all municipal health departments, not just Baltimore's. Most of Osler's recommendations pointed to a need of increased surveillance and public health authority. The recognition of house infection was important, particularly as it operated in the deteriorated and crowded housing conditions in which the poor lived, where "the patient can scarcely avoid contaminating the house in which he lives." A high proportion, 66%, shared a bed at night. Osler therefore called for tenement regulation based on "the number of persons in each house." Houses, however, were only part of

the problem. Over the past two years, the 726 dispensary patients had lived in 935 houses, indicating a high level of mobility that could hamper all but the most heroic surveillance efforts. A program of "compulsory notification" and education, "conducted by trained visitors, women preferably," as had been implemented in New York City and Baltimore, was therefore absolutely necessary for all cities' antituberculosis efforts. Where tenement reform proved ineffective, Osler called for "the wholesale condemnation of unsanitary streets and blocks," and the rebuilding at municipal cost of new housing, a program, as Osler pointed out, that currently was being conducted in Glasgow.¹⁸

PUBLIC HEALTH CARTOGRAPHY

Such recommendations were generally endorsed by Baltimore's public health community. Because of the expenditure and the infringement upon personal liberty and property rights they entailed, however, the public would have to be convinced by health officials possessing scientific authority and technical mastery. During an era of putatively expanding democratic processes and the rationalization of urban government as well as space, a tax-paying and voting public had to be convinced of the appropriateness of proposed public health actions and the surrender of rights and tax contributions such actions would entail.

The campaign was begun in earnest. For the purpose of visually representing tuberculosis infection to the lay public, it was during the same year as the publication of Adelaide Dutcher's report that Assistant Commissioner of Health C. Hampson Jones began to construct the city's first tuberculosis morbidity and mortality spot maps. Like Hermann Biggs in

¹⁸ Osler, "The Home in its Relation to the Tuberculosis Problem," New York Medical News 83:24 (12 December 1903): 1108.

New York City, Jones and the CHD had encountered significant resistance from private physicians. Although in 1900 citywide reporting was far from complete, tuberculosis mortality maps were much more so, and both played a crucial rhetorical role in the city's campaign to sway public opinion and to decrease physicians' opposition. In 1901, when the City Health Department began to annually publish tuberculosis spot maps, the Health Commissioner lauded these maps as "a new and interesting feature" in public health research.¹⁹ They were in fact but a recent example in a century-long history of public health cartography, dating back to the contagionist debates of the early- to mid-nineteenth century, as Lloyd Stevenson has shown.²⁰

¹⁹ Annual Report of the Department of Public Safety, Sub-Department of Health for the Fiscal Year Ended December 31, 1900 (1901), 19.

²⁰ Clearly illustrating the ambiguity inherent in medical theory and the representational instability of the map, each side of the contagion debate used disease cartography to promote germ theory (then called importationism) or local cause explanations (such as miasma), respectively. Both yellow fever and cholera were central to these etiological debates. Anticontagionists typically espoused the doctrine of "local origin", arguing that diseases arose in areas where putrescence, filth, and climate produced toxins, or "effluvia", which, when ingested or inhaled, produced the disease. Contagionists, on the other hand, likewise believed local conditions promoted the disease, but held that some sort of germ (often conceived as a biological agent, not an inert toxin), allowed to flourish in filth, moved from host to host. Focusing either on the distribution of filth or the routes or vectors that a pathogen was presumed to travel, respectively, both anticontagionism and contagionism were geographically oriented, and both used spot maps of yellow fever to prove their case. One side correlated elevated incidence to local conditions of filth, relying upon common knowledge of affected areas to support their claims, while the other side linked elevated incidence to proximity to a seaport or some other known or suspected route of ingress (because contagionists so often focused upon the possibility that epidemics were brought via ports from foreign lands, they were sometimes known as "importationists"). One of the earliest epidemiological spot maps, for example, Valentine Seaman's of cases of yellow fever in New York City (1798), emphasized areas that had not been effectively cleaned since his last study, in 1795. By doing so, Seaman built a cogent (though later invalidated) argument for miasma as the disease's causative agent. Seaman, "An Account of the Epidemic Yellow Fever as it Appeared in the City of New-York in the year 1795; Containing Besides its History, Etc., the Most Probable Means of Preventing its Return and of Avoiding it in Case it Should Again Become Epidemic", in Noah Webster, ed., 1796; and "An Inquiry into the Cause of the Prevalence of the Yellow Fever in New-York," The Medical Repository 1:3 (1 February 1798); Lloyd G. Stevenson, "Putting Disease on the Map: The Early Use of Spot Maps in the Study of Yellow Fever," Journal of the History of Medicine 20:3 (1965), 236, 261.

Similarly, a brief and geographically isolated epidemic in New York City of what was thought to be yellow fever in the 1820s caused momentary confusion when it was discovered that most of the victims were black, since African Americans were believed to be comparatively immune to the disease. New York health officials fell back on class stigmas, reasoning that the black victims who were struck were "dissolute and intemperate", and thus vulnerable to a disease that ordinarily, so they believed, would have left them unharmed. Although Stevenson's approach to epidemiological maps is different from mine (Stevenson's discussion of the Bancker Street epidemic comes in the context of his general discussion of the use of spot maps as proof of contagionism or anticontagionism, and he does not specifically examine the class and race implications of this controversy), of the nine that he selected

Yet the political stakes were somewhat different in the late nineteenth century. After all, tuberculosis maps were not merely the product of mortality surveillance. In years to come they were also marshaled as evidence and publicly displayed in argument for the expansion of the surveillance net and of public health budgets.

C. Hampson Jones, more than any of his colleagues in the City Health Department, was responsible for the modernizing course the Department had begun to take. He had lobbied

(including Seaman's), he notes that "the evidence [for or against the contagiousness of yellow fever] provided by maps was merely ancillary" to the argument (Stevenson, 1965, 247-248). Nonetheless, the Bancker Street incident shows in bas relief how racial suppositions become embedded in ostensibly non-racialized epidemiological investigations.

Most famously, John Snow used spot maps showing deaths in an area of London during the 1854 cholera epidemic to argue that the disease was primarily water-borne. The culprit, Snow discovered, was the water company at Southwark and Vauxhall, which drew its water from the lower Thames, at which point the river was contaminated with sewage. In 1854, homes serviced by the Vauxhall works suffered a cholera mortality rate of 71 per 100,000 population. The population which drew its water from the Lambeth works (London's other water company), which provided pure water, suffered only five deaths per 100,000. Snow's map is reproduced in his On the Mode of Communication of Cholera, second ed., London, 1855. See also Charles E. Rosenberg, The Cholera Years: The United States in 1832, 1849 and 1866, Chicago: University of Chicago Press, 1962, 193-97, 199-200; and Lloyd G. Stevenson, "Putting Disease on the Map: The Early Use of Spot Maps in the Study of Yellow Fever," Journal of the History of Medicine 20:3 (1965), 226-261.

It is also worth mentioning another genealogy within disease cartography which technically had little in common with Baltimore's tuberculosis maps. Regional maps had long been put in the service of scientists who had begun to turn their attentions to regional climate and local health conditions in various parts of the world. The works of Johann Peter Frank (1779) and Leonhard Ludwig Finke (1784-1795) are examples of this drive to correlate health and disease with geography. Both discussed local customs and natural conditions in their considerations of the prevalence of diseases, inspiring other physicians and naturalists to produce similar studies. By 1850, a number of texts had posited a relationship between the global geography of racial distribution and of various fevers. Many early maps dealing with prevalence of disease explicitly made race a category of analysis, representing disease prevalence a reflection of the interaction of climate and human populations. See, for example, Josiah Nott and George Gliddon et al., Types of Mankind or, Ethnological researches: based upon the ancient monuments, paintings, sculptures, and crania of races, and upon their natural, geographical, philological and Biblical history, J.B. Lippincott, Grambo & Co., 1854; John Beddoe, The Races of Britain, 1885; William Z. Ripley, The Races of Europe, 1899. In their sequel to Types of Mankind, Nott and Gliddon, included chapters on "Acclimation; or, the Comparative Influence of Climate, Endemic and Epidemic Diseases, on the Races of Men," and "The Geographical Distribution of the Simiae in Relation to That of Some Inferior Types of Men." In the latter they included a "tinted Map containing 54 Monkeys and 6 human portraits" to illustrate a correlation between human evolution and the geography of race. See Nott and Gliddon, Indigenous Races of the Earth; or, New Chapters of Ethnological Inquiry; including monographs on special departments of philology, archaeology, comparative geography, and natural history, Philadelphia: J.B. Lippincott & Co., 1857. See also George Rosen, "Leonhard Ludwig Finke and the First Medical Geography," in E. Ashworth Underwood, ed., Science, Medicine and History: Essays on the Evolution of Scientific Thought and Medical Practice Written in Honour of Charles Singer, London: Oxford University Press, 1953, vol.2, 186-193; and Mark Harrison, "'The Tender Frame of Man': Disease, Climate, and Racial Differences in India and the West Indies, 1760-1860," Bulletin of the History of Medicine 70:1 (1996), 68-93.

vigorously for the establishment of a municipal infectious disease hospital, played a part in the creation of a bacteriological laboratory within the Health Department, and set much of the tone of policy and research within the department, even more than his patronage-appointed superiors, Commissioners James Bosley (1900-1913) and Nathan Gorter (1913-1915). A native Baltimorean, Jones had received his medical degree from the University of Edinburgh and returned to his home to practice privately. Like so many of his counterparts, from across the Atlantic Jones had brought back the latest knowledge and techniques in medicine and bacteriology, and had combined it with the social vision that had also informed so much of the Progressive movement. Like the nationally prominent William Welch, William Osler, and Hermann Biggs, Jones was one of those public health modernizers who were responsible for the introduction of innovative epidemiological techniques to Baltimore and the United States. His talents in Baltimore did not go unnoticed, and his career as a health official began soon after his return from Europe, with his appointment as a part-time sanitary inspector. In 1898 he was appointed Health Commissioner by Republican reform Mayor William T. Malster, but was demoted two years later, to Assistant Commissioner, by the new, Democratic, Mayor, Thomas Hayes. As Assistant Commissioner, however, Jones's stature was only slightly diminished, as it was generally recognized that he was more competent than his superior, Health Commissioner James Bosley.²¹

Presenting his maps at a meeting of the Clinical Society of Maryland in April 1901, Jones noted that "a large number of deaths occur in those portions of the city where narrow streets and

²¹ Harry F. Dowling, "Politics, Medical Education and the Control of Contagious Diseases: Sydenham Hospital of Baltimore," Journal of the History of Medicine and Allied Sciences 40:1 (January 1985), 5-21

alleys exist, where unsanitary conditions of the soil prevail, and where the houses are overcrowded.” In calling for legislative measures that would “bring about a better condition of the houses and soil by the establishment of a proper drainage system,” Jones indicated his subscription to house infection theory and to a vision of public health authority that had the power to transform the city landscape. As rhetorical devices, spot maps were crucial.

Of course, the maps had their limitations, since they showed residence, not occupational address, of decedents. Housewives and servants (public or private) contributed 299 of the 1154 TB deaths in 1900. For presumably all of the former and a large minority of the latter, place of habitation and occupation were the same. On the other hand, office clerks contributed another 63 tubercular deaths, and laborers, 114 (another 326 came from unknown occupations, probably, as Jones suggested, because the deceased had been unemployed for a long time). No maps had been produced correlating workplace with tubercular deaths (nor would any ever be), but Jones nonetheless concluded that the high numbers of office workers and laborers on the mortality rolls indicated that the state ought “to have laws passed that will protect the clerk in his counting-room and the laborer at his trade.”²²

²² Jones, “Distribution of Tuberculosis in the City of Baltimore,” Maryland Medical Journal 44:8 (August 1901), 347.



Figure 3: Spot map of tuberculosis deaths, 1891-1900, printed in the 1901 Annual Report of the Baltimore City Health Department. This map, with others, appeared at the 1904 Tuberculosis Exposition. (Baltimore City Archive).

Fellow health official H. Warren Buckler, on the other hand, viewed Jones's maps as evidence of the threat of contagion from poor to wealthy, black to white. Despite the fact that Baltimore was home to several nationalities that, in 1900, physicians often perceived as "races" (Irish, Germans, Polish, Slovakian, Romanian, Jews, etc.) health officials in Baltimore used red and blue dots to mark only "white" and "colored." In January 1901, he began his address before

the Laennec Society by congratulating Baltimore on having a TB mortality rate that was “not at all unfavorable” when compared to other large cities, “especially when one considers our large negro population, among whom the disease is especially fatal.” Baltimore, “even with its 80,000 or more negroes,” was not “the hotbed of tuberculosis as many would believe,” suggesting that blacks’ supposed racial predisposition to tuberculosis made Baltimore a statistical outlier of sorts. Whereas conditions of living and work stood out for Jones, racial composition of the death rolls and tuberculous neighborhoods were of primary interest to Buckler. He called his audience’s attention to color-coded pins on the mortality map indicating racial identity, and noted that the city’s suburban areas (in Wards 9, 11, 12, 16, 17, 18, and 19), although “thickly settled in some portions,” had a noticeably lower than average tuberculosis mortality, around six percent of all deaths. In the white-occupied area surrounding Eutaw Place between Druid Hill and Park Avenues (in the Fifteenth Ward), tuberculosis deaths among its residents were rare, and it reported no new cases of the disease during the year 1900.²³ Just slightly further west, and in the Fourteenth Ward (formerly the Eleventh Ward), however, lay Lower Druid Hill. There, “where our melanotic citizens predominate,” and in close proximity to Eutaw Place’s affluent whites, Buckler warned, “the death rate from consumption is little short of appalling.” Indeed, for the Fourteenth Ward generally, tuberculosis deaths accounted for over 18 percent of all mortality, and there was “scarcely a block in this ward” in which not at least one person had succumbed to the disease in the year 1900. Flick’s theory of house infection, of which Buckler approved wholeheartedly, said absolutely nothing about house-to-house contagion (a prospect that, even to early twentieth-century physicians, must have seemed highly unlikely), yet for him

²³ Commissioner of Health James Bosley in Annual Report of the Department of Public Safety, Sub-Department of Health for the Fiscal Year Ended December 31, 1900, 1901, 19. RG19, BCA.

it was clear that Lower Druid Hill presented “an especial menace to those portions of the city. . . being free from the disease.”²⁴

The difference between Jones's and Buckler's interpretations of the same maps hinged largely on their views of class and “race.” Jones's calls for legislation addressing occupational health revealed a broader vision of tuberculosis, although his maps, which showed residence (not place of work) and “racial” identity were necessarily limited in this regard. Buckler in contrast was more preoccupied with blacks, and made among them little distinction regarding occupations (in contrast, he explained high tuberculosis mortality in one white neighborhood by its residents being mill hands who presumably would have contracted the disease at work). Buckler was less inclined to point to housing conditions, enjoining his audience to understand that “overcrowding, poor ventilation and lack of fresh air and sunshine are not the sole causative factors,” but that “certain districts seem to be more especially tainted with tuberculous infection than others, and that to a certain extent, where one lives seems to be as important as how one lives.”²⁵

Both Jones and Buckler called for a stepped up campaign of public education in an effort to “warn the public as to the communicability of the disease” (on this point, Buckler emphasized black laundresses and servants as vectors of transmission).²⁶ The two physicians were also emphatic about the need for increased surveillance, for, as Buckler put it, despite the enactment five years before of mandatory registration of consumptives, there had been “no means of

²⁴ H. Warren Buckler, “Pulmonary Tuberculosis in Baltimore,” Johns Hopkins Hospital Bulletin 12 (September 1901), 288-90; Laws of Maryland, 1901, chapter eight. N.B.: In 1901, Baltimore's twenty-four wards were renumbered. The Fourteenth Ward, discussed by H. Warren Buckler, was once the Eleventh Ward.

²⁵ Buckler, 1901, 289.

²⁶ C. Hampson Jones, “Distribution of Tuberculosis in the City of Baltimore,” Maryland Medical Journal 44:8 (August 1901), 347.

ascertaining either the number or the location of cases” in Baltimore.²⁷ Jones was heartened that previous objection to mandatory reporting “on the part of the physicians and the laity. . . is becoming less and less every year,” and announced a new era of cooperation between private physicians and the CHD, marked by the “opening of the municipal laboratory to assist the [private] physician in making diagnoses of diseases [which have] greatly increased our information of the distribution of the disease.”²⁸ In the meantime, however, reporting was woefully inadequate. Jones’s incidence maps were necessarily incomplete, since, even in 1900, case reporting had been performed largely by visiting nurses and other CHD personnel.²⁹ The geographic distribution of active cases could be inferred from the mortality map, but only on limited terms. As Jones pointed out, while reported cases and deaths occurred in “about the same territory,” the lion’s share of deaths were “reported from residents of the alleys, while cases are reported from residents in the streets.” This, Jones deduced, was “due to the fact that the many cases that exist in our alleyways are already so far advanced when the physicians are called to them that it is scarcely necessary to make a bacteriological examination to determine the diagnosis.”

²⁷ H. Warren Buckler, “Pulmonary Tuberculosis in Baltimore,” (read before the Laennec Society on 30 January 1901), Johns Hopkins Hospital Bulletin 12 (September 1901), 289.

²⁸ C. Hampson Jones, “Distribution of Tuberculosis in the City of Baltimore,” Maryland Medical Journal 44:8 (August 1901), 345.

²⁹ Maryland’s and Baltimore’s modernized tuberculosis reporting laws required information concerning each patient’s occupation, race, and place of residence. In Baltimore, of the 1,154 tuberculosis deaths that occurred in 1900, 371 (or approximately 32%) occurred among Negroes. These 371 TB deaths constituted 14.23% of all Afro-Baltimorean deaths, while the white number (782) constituted only 9.66% of all white deaths. See C. Hampson Jones, “Distribution of Infectious Disease in Baltimore,” Maryland Medical Journal 44 (August 1901)

Why alley residents delayed consultation with a physician, however, Jones did not attempt to speculate, but it was clear that there were many more consumptives in Baltimore than the reporting mechanisms currently in place could deliver. Using a popular epidemiological formula that held that for every tuberculosis death in a year there existed ten active cases surviving to the next year, Baltimore officials estimated the living tuberculous population in 1900 at slightly more than 10,000.³⁰ Acknowledging that nearly two percent of the city's population had the disease, seven thousand or more of whom were likely "too poor to be able to take decent care of themselves" and were probably spreading it to family and associates, researchers reasoned that identifying the city's afflicted and ascertaining exactly where they resided was the first logical step in treating patients and controlling the spread of the disease.³¹

CONSUMPTION AND CONSUMPTION

As in debates surrounding house infection and mandatory registration in the 1890s, that varied interpretation of evidence could hinge on "race" – that alchemy of skin color and gendered productive relations-- was illustrated by the simultaneous presentations of spot maps by Jones and Buckler in 1901. Jones more closely adhered to those principles of public health that combined sanitary and class considerations with bacteriological discovery. Buckler's interpretation, a reification of "race" as the relation between social caste and high mortality and

³⁰ Ibid; William Osler, "The Home Treatment of Consumption," Maryland Medical Journal 43:1 (January 1900), 8. This formula, stating that every one tuberculosis death represents ten live cases, was used frequently in the early twentieth century. It perhaps was employed first by Sir Robert Phillip (1857-1939). See Robert Phillip, A thousand cases of pulmonary tuberculosis: with etiological and therapeutic considerations, Edinburgh: Morrison & Gibb, 1892; The anti-tuberculosis programme: co-ordination of preventive measures, being a lecture delivered . . . before the International congress on tuberculosis at Washington, D.C., 21st September to 12th October 1908; The role of the consumption dispensary in the tuberculosis campaign: a lecture delivered in the Theatre of the Royal Dublin Society, at Dublin, on 21st April, 1909. Martin F. Sloan, "The Urgent Need of Hospital Facilities for Tuberculous Negroes," Southern Medical Journal 10:8 (August 1917), 655.

³¹ H. Warren Buckler, "Care of the Indigent Tuberculous," Maryland Medical Journal 44:8 (August 1901), 350.

of disease as deriving at least in part from geographic proximity, more readily lent itself to infectious fear, the anxieties Negrophobe whites harbored towards black and non-"Caucasian" urban populations with whom they had an uneasy and sometimes threatening interdependence.

This was the subtext of "race" in the city. In 1900, Adelaide Dutcher had described the topography of race as "natural," not sociopolitical. Similarly, and foreshadowing the spot map, she viewed the geographical distribution of disease and contagion as a function more of residence than occupation. In a section titled "Occupation," she conspicuously downplayed the possibility that the workplace could be the source of contagion to employees, and that the workers' families could thus be victims. Because some of her patients worked in factory positions where they could spread the disease to the uninfected, "the occupation of some of these patients has a practical bearing on their relation to society." Such transmission could be between workers, but, more insidiously, via the "the materials worked upon" (Dutcher specifically cited individuals producing willow ware), the manufactured product of their labor, between workers and consumers.³²

The geography of disease transmission was therefore intimately imbricated in the geographic articulation of urban capitalism, and germs were more than metaphors for the alienation of labor and the production of commodities. This was a dystopian vision when compared to the celebrations of the positive good to be realized by economic specialization and the availability of mass-produced goods for the betterment of the home and body. The development of urban consumerism, by Frederick Law Olmsted's account, for example, was reflective of a gendered economy. While men left the country for the city in search of work,

³² Adelaide Dutcher, "Where the Danger Lies in Tuberculosis," The Philadelphia Medical Journal 6:22 (1 December 1900).1031.

their wives and daughters urged them to do so because of the consumer attractions of city life and “the amount of time and labor, and wear and tear of nerves and mind, which is saved to them by the organization of labor in those forms, more especially, by which the menial service of households is simplified and reduced.” Urban housewives (Olmsted does not mention men as consumers or women as workers), as opposed to their country counterparts, were saved time by the exchange of money for services provided by “the butcher, baker, fishmonger, grocer, by the provision venders of all sorts, by the ice-man, dust-man, scavenger, by the postman, carrier, express-men, and messengers, all serving you at your house when required.”³³ For Dutcher and the public health community to which she belonged, however, the wage of consumption was consumption.

This was not likely an indeliberate choice. In American Progressive fashion, many public health professionals were likely to represent contagious disease as something that insinuated itself into the otherwise desirable divorce between producer and consumer, thereby sidestepping a potential critique of capital itself. Since many sweatshop workers were likely to spend more time at work than at home, Dutcher may have more easily used the precepts of house infection to tell the tale of someone whose work conditions were detrimental to his health and thus put him and his family in jeopardy. Indeed, Dutcher very well could have used the “soil and seed metaphor” to argue, as later advocates did, that strenuous and long work in the close confines of the sweatshop weakened the individual’s constitution and thus left him vulnerable to developing the disease, if not contracting the infection.

³³ See “Public Parks and the Enlargement of Towns,” American Social Science Association (Cambridge, MA): Riverside Press, 1870, rpt in Frederick Law Olmsted, Civilizing American Cities: Writings on City Landscapes, ed., S.B. Sutton, New York: Da Capo Press, 1997.

In fact, although Maryland had passed sweatshop legislation in 1894, it was hardly popular among manufacturers and industrial interests who appeared willing to legally challenge it to the end, effectively stifling any discussion of its implementation.³⁴ The law initially does not appear to have been rigorously enforced from Annapolis, nor had there been given much study on the state or local level to workplace infection. Dutcher, a student in a new curriculum and without an established career, would not have gained much political capital by launching a crusade against health nuisances in sweatshops.³⁵ Instead, she represented the worker's family and home as that which placed the sweatshop and consumers in harm's way. Admitting that "statistics are too limited to admit of any conclusions," Dutcher had been nonetheless confident enough to geographically fix disease to place, asserting that "Baltimore houses are becoming *centers of infection*."³⁶ Two years later, the sweatshop law's progressive champion, C. Hampson Jones, had to admit that, "little at this time can be said about the contributing causes of death from [tuberculosis] amongst the white people" (Jones assumed, however, that black tuberculosis was contracted in the home). That "artisans and mechanics" and low-level office workers (clerks and accountants mainly) seemed particularly liable to develop the disease

³⁴ James B. Crooks, Politics and Progress: The Rise of Urban Progressivism in Baltimore, 1895 to 1911, Baton Rouge: Louisiana State University Press, 1968, 166-167.

³⁵ In this respect, Dutcher was typical of much of the tuberculosis movement. As Michael Teller has argued, tuberculosis societies were generally reluctant to directly address social factors "due to the difficulty of singling out a *specific* social cause of tuberculosis and to a reluctance to tackle controversial issues." Dutcher's elision of the role of commerce in contagion was hardly the first. The New Orleans's Board of Health was notoriously reluctant in the first half of the nineteenth century to adopt a contagionist stance toward yellow fever, since admitting the disease's contagiousness would necessitate mandatory quarantine of ships entering the city's ports, thereby hindering commerce. For commercial considerations, London's General Board of Health "ignored some of the plain facts" regarding the communicability of cholera in the 1850s. See Teller, The Tuberculosis Movement: A Public Health Campaign in the Progressive Era, New York: Greenwood Press, 1988, 47; Lloyd G. Stevenson, "Putting Disease on the Map: The Early Use of Spot Maps in the Study of Yellow Fever," *Journal of the History of Medicine* 20:3 (1965), 226-261; Wade Hampton Frost, "Introduction" to *Snow on Cholera Being a Reprint of Two Papers by John Snow, M.D.*, New York: Hafner Publishing Company, 1965, 1936; Margaret Humphreys, *Yellow Fever and the South*, Baltimore: Johns Hopkins University Press, 1992.

³⁶ Dutcher, 1032. Italics mine.

seemed to indicate that work environment was an important factor, but unfortunately, as Jones pointed out, there were yet no “skilled inspectors” carrying out the task of policing aberrant managers.³⁷

Health officials therefore could have applied the theory of house infection – focusing as it did on built environment, and not just the home – to industrial settings. Instead, they generally used it more literally, to focus on houses, and thereby encountered little organized resistance. H. Warren Buckler's focus on blacks, particularly black women, would be echoed for decades to come as his peers increasingly deployed the threat of the infectious domestic worker to arouse public consciousness to the need of expanded and empowered public health department. The body of the tuberculous Negro domestic worker, a term that could characterize only a fraction of all black laundresses and an even smaller fraction of all black women, came to possess a power of its own, drawing from existing stereotypes of black women, and placing that body among the pantheon of derogatory imagery.

THE 1904 TUBERCULOSIS EXPOSITION

Shortly after the time that Jones, Dutcher, and Buckler were presenting their efforts before Baltimore's public, the Maryland Tuberculosis Commission (discussed in the previous chapter) had begun its study, which concluded in 1904. “All statistics show the great frequency of tuberculosis in the colored race,” the Commission reported, “and our figures bear out these general statistics.”³⁸ Yet, noting that tuberculosis reporting was far below the level at which any

³⁷ Annual Report of the Sub-Department of Health, Department of Public Safety, for the Fiscal Year Ended December 31st, 1902, 1903, 225-27. RG19, BCA.

³⁸ *Preliminary Report of the Tuberculosis Commission of Maryland, 1902-1904*, 7.

positive results could be expected, and hoping to “excite a more general public interest” in its work and in tuberculosis prevention generally, the 1902-1904 Tuberculosis Commission arranged for a large-scale public demonstration to secure popular support for its recommendations. The planning committee was chaired by Dr. Henry Barton Jacobs. Space at Johns Hopkins University's McCoy Hall was donated by the university's trustees, and between 25 and 30 January 1904, Baltimore became the nation's first city to host a tuberculosis exposition.

By any standards, it was impressive in scope. Exhibits were open between 10:00 am and 10:00 pm, including photographs, charts, glass-jarred organ specimens, and anatomical and architectural models; and addressing subjects as diverse as pathology and infection; outdoor treatment; prophylaxis; the finance and construction of sanatoria; charity; visiting nursing; and surveillance and registration. Daily lectures began at either 5:00 pm or 8:15pm. Subjects included Frederick Hoffman's “The Statistical Laws of Tuberculosis” (Monday 25 January); Lawrence Flick's “House Infection of Tuberculosis” (26 January); S. Adolphus Knopf's “Pulmonary Consumption and the Possibilities of Its Eradication . . .” (28 January); and George Adami's “Facts, Half-truths, and the Truth, About Tuberculosis” (29 January). The final evening was capped off by lantern demonstrations by Drs. William Welch, Charles H. Potter, and John B. Huber. Were a viewer not impressed by this parade of scientific leaders, or left unconvinced by their message, one of the exhibits featured portraits and partial libraries loaned by Drs. Osler, Jacobs, D. R. Lyman, and Lewis V. Hamman. The books, “over 100 volumes in all,” were not for circulation but for mere display, as if to physically demonstrate the vast amount of knowledge, accumulated over thousands of years (translations of Hippocrates's works were also

displayed) about the disease, that experts brought to bear.³⁹ At one well-attended Exhibition event, physicians combined in their display of the black tuberculous body scientific authority with Barnumesque showmanship. A Dr. Babcock of Chicago, though blind, displayed amazing powers of diagnosis before attendees when he, without hearing the patient cough and given no hint of the affliction, placed his hands upon the patient's face, chest, and back, and immediately declared "This man has tuberculosis, well advanced." As the enthusiastic applause subsided, further examination by Babcock revealed that the patient also suffered an aneurism in an artery in his back, an affliction previously unknown to everyone present, including the apparently silent patient. The patient was a Negro man, approximately sixty years of age.⁴⁰

Indeed, displayed at the exposition were several exhibits dealing with Baltimore's and the nation's African-American population. More specifically, many of these exhibits offered analysis of African Americans' position in the etiology of the disease. Reiterating Dr. Buckler's comments of 1901, photographs depicting the city's black neighborhoods showed spectators where tuberculosis was likely to breed and from whence it could travel via the black domestic worker or in-home laundress who either unwittingly or callously combined a commerce in service with a traffic in germs. Reports generated by personnel connected with Johns Hopkins Hospital and the Baltimore City Health Department (CHD) provided a personal, urban flâneur-meets-social scientist, narrative reminiscent of popular travelogues from a century just passed. From the images and text presented at the 1904 Tuberculosis Exposition, spectators were led to conclusions already drawn by Baltimore's public health officials: it was the city's blacks who

³⁹ John N. Hurty, "Report on the Tuberculosis Exposition Held Under the Auspices of the Tuberculosis Commission of Maryland, in Baltimore, for the Week Commencing January 25, 1904," *Indiana Medical Journal* 22:8 (February 1904), 317.

⁴⁰ John N. Hurty, "Report on the Tuberculosis Exposition Held Under the Auspices of the Tuberculosis Commission of Maryland, in Baltimore, for the Week Commencing January 25, 1904," *Indiana Medical Journal* 22:8 (February 1904), p322.

suffered the disease in the greatest proportions, and who posed one of the greatest health threats to the city's white population.

In this regard, Jones's spot maps were prominently displayed at the Exposition, as was another, showing the residences of decedents between the years 1891 and 1900. Both maps revealed Lower Druid Hill (also known as the Biddle Alley neighborhood) as having the highest concentration of tuberculosis deaths. To further bring home the point, a smaller map of this area showed individual houses and the number of tuberculosis deaths found in each (175 over from 1891 to 1900).⁴¹ Located in northwest Baltimore and bounded by Pennsylvania Avenue, Biddle Street, Druid Hill Avenue, and Preston Street, this black working-class neighborhood suffered a tuberculosis death rate that hovered around 950 per 100,000 people, compared with a rate of 131.9 for the city in general. CHD officials estimated that there was not one house in that area that had not seen at least one case of tuberculosis that year.⁴²

By all accounts, the Exposition was a great success. In attendance at the opening ceremony at Johns Hopkins University's McCoy Hall were regional and international dignitaries, researchers, and statisticians; the aforementioned lecturers were joined by tuberculosis philanthropist Henry Phipps, William Welch, D. E. Salmon, Theodore Potter, and Vincent Bowditch. Some 1,200 others had come to attend, and as many as 200 were turned away when the room had reached capacity. Conveners neglected to take an official tally, but when the

"Report on the Tuberculosis Exposition," in Report of the Tuberculosis Commission of Maryland, 1902-1904, 77. Library of the Medical and Chirurgical Faculty of Maryland, Baltimore (MedChi).

⁴² Karen Olson, "Old West Baltimore: Segregation, African-American Culture, and the Struggle for Equality," in Elizabeth Fee, Linda Shopes, and Linda Zeidman, eds., The Baltimore Book: New Views of Local History, Philadelphia: Temple University Press, 1991; Janet E. Kemp, Housing Conditions in Baltimore: Report of a Special Committee of the Association for the Improvement of the Condition of the Poor and the Charity Organization Society, Baltimore: The Federated Charities, 1907; Bonnie Kantor, "The New Scientific Public Health Movement: A Case Study of Tuberculosis in Baltimore, Maryland, 1900-1901," (D.Sc. Diss., School of Hygiene and Public Health, Johns Hopkins University, 1985).

Exposition finally closed, commentators estimated that in all, over 10,000 individuals braved the cold of that fourth week of January to view the nation's first Tuberculosis Exposition. The success of the Exposition soon became legendary – in 1908 the Maryland Association for the Prevention and Relief of Tuberculosis, formed in December 1904 as an outgrowth of the Tuberculosis Commission's work, exaggeratedly claimed the number of visitors to be “upward of fifty thousand.”⁴³

The exposition was also favorably reviewed in the lay and medical press. Toronto's Canadian Journal of Medicine and Science approved of the exposition as something that ought to be used in antituberculosis work everywhere.⁴⁴ S. Adolphus Knopf, who contributed material to the Exposition, described it in a German tuberculosis medical journal as “one of the most important events in the history of the antituberculosis crusade in America,” and was particularly impressed with the “‘Lung block’, the worst area, consisting of two squares crowded with negroes.”⁴⁵ In her review of the exposition, nationally prominent nurse Adelaide Nutting called attention to Baltimore's expanding net of surveillance and administration, pointing to the growing influence of the CHD, the Board of Health, the Charity Organization Society, and the IVNA as administrative nodes. Indeed, the significant contributions to the exposition from the various District and Visiting Nurses' Associations from around the country in the form of letters, exhibits and data augured, Nutting believed, their future prominence in the antituberculosis

⁴³ “Throng At Exposition. Interest In Movement To Fight Phthisis On The Increase. Display Will Close Tonight. Dr. Adami Speaks On ‘Facts, Half Truths And The Truth About Tuberculosis,’” [no journal title] 30 January 1904. Henry Barton Jacobs Tuberculosis Scrapbooks, Alan Mason Chesney Archives, Johns Hopkins University; Report of the Maryland Association for the Prevention and Relief of Tuberculosis, 1907-1908, 21.

⁴⁴ J. H. Elliott, “The Baltimore Tuberculosis Exposition,” Canadian Journal of Medicine and Science 15 (1904) 231-35.

⁴⁵ S. Adolphus Knopf., “A Visit to the American Tuberculosis Exposition at Baltimore, Maryland, with Short Reports of the Lectures of Hoffman, Flick, Ravenel, Knopf, Adami, Welch, Huber and Osler,” Zeitschrift fur Tuberkulose 6:2 (1904), 106-115.

crusade. As the primary agents of tuberculosis control, tuberculosis nurses would soon form a “national society or federation of district nurses” as “the next necessity in consolidating and making more efficient” tuberculosis work.⁴⁶

With contributions from several cities and nations, the Exhibition was an early expression of the strengthening professional networks that became a hallmark of the antituberculosis crusade. These networks included public health officials, city planners, social workers, physicians and researchers, and politicians, and emphasized the efficiency to be realized through cooperation, professional association, and communication. Thus the reports, maps, and photographs generated by the Baltimore City Health Department, Johns Hopkins Hospital, and various other Baltimore institutions found audiences outside of the city and state. Particularly among the Southern cities (among which Baltimore claimed membership), Baltimore was a pace-setter for urban reform, and its public health community often and self-consciously compared itself to its Northern and Midwestern counterparts in New York City, Philadelphia, Boston, Cincinnati, and Chicago. Throughout the United States at the turn of the century, the study of “lung blocks” or “plague spots” was sufficiently proliferate to indicate a trend in how health officials regarded urban space, generally constructing narratives that reified inequality as a matter of indigenous pathology.⁴⁷

⁴⁶ Adelaide Nutting, “The Tuberculosis Exposition in Baltimore,” *American Journal of Nursing* 4 (April 1904), 497-499.

⁴⁷ In 1904, New York City tuberculosis expert Dr. John Huber noted, “One may grasp the idea in a glance upon the maps of New York City districts which its Health Board has prepared under the medical directorship of Dr. Hermann M. Biggs. By far the greatest number of our consumptives are in the poorer districts; eleven of them, for instance, dying in one year in a house on the ‘lung block’.” See John B. Huber, “The Great White Plague,” *Popular Science Monthly* 65 (November 1904), 303.

In the context of United States Chinatowns, this has been shown. See Charles McClain, “Of Medicine, Race, and American Law: The Bubonic Plague Outbreak of 1900,” *Law and Social Inquiry* 13:3 (1988), 447-513; JoAnne Brown, “Crime, Commerce, Contagionism: The Political Languages of Public Health and the Popularization of Germ Theory in the United States, 1870-1950,” in Walters, Ronald G., ed., *Scientific Authority & Twentieth-*

Aside from the publication of photographs (which the antituberculosis movement in fact increasingly would use after 1904) and the proliferation after 1912 of dramatic silent films with anti-tuberculosis themes, perhaps no better manner of public display could have been conceived than the format of the exposition. Patterned after the World Exhibition, or World's Fair, movement begun in the nineteenth century (the first was London's World's Fair in 1851), it was proven in its popularity by 1900, when the New York City Tenement House Exhibition adapted the World's Fair format for social reform purposes.⁴⁸ In the age of colony-building, the World Exhibition had at once inculcated and satisfied a desire for knowledge of the Orient.⁴⁹ This metropolitan desire for the consumption of knowledge emerged from the same desire attached to the consumption of goods – the World Exhibition typically featured an ordering of spaces, races, and, importantly, extractive production in silk, rubber, cotton, sugar, etc., while masking the colonial relations that made their production possible. One could, in a World Exhibition, visit strange lands and safely gain mastery over them through a simulation of the colonizer's experience and the fantasy of consumption.

The fantasy was spatially induced and managed. Aside from offices reserved for Hopkins University's president, and directors, the entire first floor of McCoy Hall was given to

Century America, Baltimore: Johns Hopkins University Press, 1997; Nayan Shah, Contagious Divides: Epidemics and Race in San Francisco's Chinatown, Berkeley: University of California Press, 2001; Susan Craddock, City of Plagues : Disease, Poverty, and Deviance in San Francisco, Minneapolis: University of Minnesota Press, 2000. See also Cynthia Neverdon-Morton, Afro-American Women of the South and the Advancement of the Race, 1895-1925, Knoxville: The University of Tennessee Press, 1989, 179-180. On narrative and reification, see Georg Lukács, The Theory of the Novel: A Historico-Philosophical Essay on the Forms of the Great Epic Literature, trans. Anna Bostock, 1971; Fredric Jameson, The Political Unconscious: Narrative as a Socially Symbolic Act, Ithaca: Cornell University Press, 1981.

⁴⁸ De Forest, R. W. and L. Veiller (1903). The Tenement House Problem, Including the Report of the New York State Tenement House Commission of 1900. New York, The Macmillan Company; Michael E Teller, The Tuberculosis Movement: A Public Health Campaign in the Progressive Era, New York: Greenwood Press, 1988, 60-62.

⁴⁹ By "the Orient," I mean the idea of a place, a conceptualization made famous, of course, by Edward Said.

the Exposition. A conference room normally used for faculty meetings was reserved for the bacteriological and pathological exhibits. In the center of the first floor was the Assembly Hall, capable of comfortably seating several hundred and in which speakers delivered their addresses. Around the Assembly Hall there were ten sets of exhibits, each set with several exhibits contributed by various donors. The Exposition's planners had designed it so that the exhibits were typologically "arranged in logical order of place and sequence so as to facilitate their inspection by those interested and their demonstration to sections and classes."⁵⁰ Because each section exited upon the next, viewers had to view the exhibits in a specific order, in essence walking through a narrative. The first section, on statistics (featuring charts and graphs) led to one on tenements and housing, illustrating the practical effects of house infection. The next section, on "State and municipal prophylaxis," featured maps of New York City's distribution of tuberculosis, highlighting areas of high incidence including New York's own Lung Block. Here the Baltimore CHD provided its own maps of the city and of its own Lung Block. Following sections seemed to offer solutions: "hospitals and sanatoria", "domestic prophylaxis and house hygiene" (including a model room and before and after photographs), and "district nursing." The final section featured manufactured products that could be purchased cheaply to prevent the spread of tuberculosis.

⁵⁰ The sections were arranged in this order: 1. "Section on statistics of tuberculosis"; 2. "Section on tenements, sweatshops and factories" (contributed largely by New York City and Baltimore); 3. "Section on State and municipal prophylaxis"; 4. "Section on hospitals and sanatoria"; 5. "Section on books and portraits"; 6. "Section on domestic prophylaxis and house hygiene"; 7. "Section on district nursing"; 8. "Manufacturing exhibits"; 9. "Exhibit of the National Sanatorium Association of Canada"; and 10. the "Pathological – Anatomical Room: -- Pathological anatomy, bacteriology, photomicrography (Pathological models)." See "Report on Exhibits and Demonstrations of the Exposition," in Report of the Tuberculosis Commission of Maryland, 1902-1904, Baltimore: Sun Job Printing Office, 1904, 68, 69.

The Tuberculosis Exposition movement that began in Baltimore in early 1904 and thereafter spread across the country was a modified version of the transatlantic phenomenon of the World Exposition. Each exposition repeated this format, reiterating the fantasy. For a white middle-class audience, tenements and ethnic ghettos could be as foreign a place as the Levant or Peking, but were kept in the exposition at a safe distance by their display in photographs, maps, dioramas, and diagrams. In fact, by introducing to the public the theory of house infection, the Baltimore Exposition was the beginning of an aggressive national campaign to deploy and popularize the image of the incorrigible consumptive and the dysfunctional environment in which he or she dwelled. House infection had once been controversial in the 1890s, but exhibits dealing with the phenomenon and the popular reception of Lawrence Flick's delivery of his paper on the subject signaled the public's acceptance by 1904 of his theories.⁵¹ The Exposition also contributed to the spread of tuberculosis cartography. By 1905, Chicago's Tuberculosis Committee, working with the Visiting Nurses' Association, had already begun to produce spot maps for mass viewing, as had their counterparts in Cincinnati. Like Baltimore's these cities' maps were necessarily incomplete and weighted toward the poor because they relied disproportionately on data coming from "every house whence a consumptive patient is brought to the hospital."⁵²

Although many of the exhibits of the initial Baltimore Exposition were consumed in Baltimore's great fire of 1904, those concerning the Lung Block were among the survivors. They continued to show around the state, and three years later, the Maryland State Board of

⁵¹ "Report on the Tuberculosis Exposition," in *Report of the Tuberculosis Commission of Maryland, 1902-1904*, 60-87.

⁵² Samuel Hopkins Adams, "Tuberculosis, the Real Race Suicide," *McClure's* 24 (January 1905), 240.

Health had become so impressed with their impact upon audiences that it requested its submission to the national Traveling Tuberculosis Exhibit of 1907-08, viewed by over 100,000 persons by its conclusion (1,000 viewed it at Baltimore's Colored YMCA between 7 and 15 January 1908).⁵³ Baltimore's spot map, accompanied by a photograph, captioned, "Baltimore's 'Lung Block' -- There Has Been from One to Eight Deaths from Consumption in Every House on Both Sides of the Street," officially made Lower Druid Hill an icon for the tuberculous neighborhood.⁵⁴ Again, Lower Druid Hill was included in the Maryland Association for the Prevention and Relief of Tuberculosis (MAPRT) submission to the 1908 International Tuberculosis Congress, held in Washington, DC, at which the Baltimore City Health Department, the Maryland State Board of Health, and the MAPRT took several awards for their exhibits.⁵⁵ Meanwhile, in 1905, the newly formed National Association for the Study and Prevention of Tuberculosis collaborated with the New York City Tuberculosis Committee to there stage an exposition based on the one that showed a year before in Baltimore. This exposition, too, featured a Lung Block – New York City's, populated largely by Irish, Jews, Italians and other eastern and southern Europeans. This exposition traveled to the Eastern, Midwestern, and Southern states between 1905 and 1911. A second, modified, version toured the Western states between 1908 and 1912. San Francisco's viewers would have arrived at the

⁵³ Program for the Traveling Tuberculosis Exhibit in the 1907-1908 Report of the Maryland Association for the Prevention and Relief of Tuberculosis, 17-20. MedChi Library. S. Adolphus Knopf, [A History of the National Tuberculosis Association: The Anti-Tuberculosis Movement in the United States](#), New York: National Tuberculosis Association, 1922, 100; [Report of the Maryland Association for the Prevention and Relief of Tuberculosis, 1907-1908](#), 21.

⁵⁴ Program for the Traveling Tuberculosis Exhibit in the [1907-1908 Report of the Maryland Association for the Prevention and Relief of Tuberculosis](#), 17-20. Medical and Chirurgical Faculty of Maryland Archive.

⁵⁵ "The Tuberculosis Congress," [Maryland Medical Journal](#) 51:9 (September 1908), 363-366; "Honors to Maryland," [Maryland Medical Journal](#) 51:11 (November 1908), 459-462; "Maryland's Exhibit In New York," Baltimore [Sun](#) 17 November 1908. Scrapbooks of the American Lung Association (Maryland chapter), Langsdale Library Special Collections, Series I Box 1.

exposition with the recent memory of outbreak of plague in Chinatown (parts of which by then had been labeled a “plague spot”) and the continuing elevated rates of tuberculosis mortality among Chinese.⁵⁶ During these years, New York City, Newark Chicago, Minneapolis, and Boston, were only the larger members of the group of cities that sponsored local tuberculosis expositions. More than fourteen states, including Maryland, also staged traveling expositions to reach residents of the smaller towns and rural districts (here the transatlantic motif of the World's Fair was less appropriate than the North American county fair).⁵⁷ All the while, residents of the nation's Lung Blocks, such as those of Baltimore's Lower Druid Hill, who viewed the exhibits may have understandably wondered (as did Egyptian viewers of the Orientalist World Exhibitions of the late nineteenth century, as Timothy Mitchell notes) whether the West had not effectively “order[ed] up the world itself as an endless exhibition.”⁵⁸

American pragmatic philosophy after all emphasized the arousal of public awareness through accessible imagery and ideas – in this regard the progressives (particularly social

⁵⁶ Richard Harrison Shryock, The National Tuberculosis Association, 1904-1954: A Study of the Voluntary Health Movement in the United States, New York: National Tuberculosis Association, 1957; Nayan Shah, Contagious Divides: Epidemics and Race in San Francisco's Chinatown, Berkeley: University of California Press, 2001.

⁵⁷ Michael E Teller, The Tuberculosis Movement: A Public Health Campaign in the Progressive Era, New York: Greenwood Press, 1988, 60.

⁵⁸ Mitchell, Timothy. "The World as Exhibition." *Comparative Studies in Society and History* 31, no. 2 (1989): 218. There arose significant controversy surrounding the representational politics of the Chicago World's Columbian Exposition in 1893. While whites staged exhibitions featuring derogatory images of American blacks, blacks themselves were effectively denied the opportunity to represent the race accomplishments that had occurred since Emancipation. This led Ida B. Wells, Frederick Douglass, Irvine Garland Penn, and Ferdinand L. Barnett to publish a long pamphlet titled The Reason Why the Colored American Is Not in the World's Columbian Exposition (1893). See also Robert W. Rydell's "Introduction" to the reprint of Wells, et al's pamphlet (Urbana and Chicago: University of Illinois Press); Rydell, All the World's a Fair: Visions of Empire at the American International Expositions, 1876-1916, Chicago: University of Chicago Press, 1984. Elliott Rudwick and August Meier, "Black Man in the 'White City': Negroes and the Columbia Exposition, 1893," Phylon 26:4 (1965), 354-61; Ann Massa, "Black Women in the White City," Journal of American Studies 8 (1974), 319-37; Anna R. Paddon and Sally Turner, "African Americans and the World's Columbian Exposition," Illinois Historical Journal 88 (1995), 19-36.

photographers, as I have noted elsewhere) maintained a conscientious interest in advertising.⁵⁹ Jane Addams would later refer to the tuberculosis exposition as an “advance in social advertising.”⁶⁰ In fact, the presentation of the spot map at the 1904 Tuberculosis Exposition served to solidify the association in the public mind of Lower Druid Hill with tuberculosis, and therefore to make, through racialization, the logic of house infection more acceptable to the public. For the purveyors of mass-produced goods or of public health policies, the racialization of tuberculous space provided an easily manipulated set of recognizable icons. Reflecting on their impressions of Baltimore's 1904 exposition, Drs. Lillian Welsh and Mary Sherwood, who had compiled Baltimore's 1891-1900 tuberculosis mortality spot map from death certificates, noted that “[t]hose citizens who are acquainted with the city will at once recognize the crowded portions and the habitations of our colored population,” referring in particular to the southwest area of the intersection of Druid Hill Avenue and North Avenue as where “the colored population predominates.”⁶¹ Baltimore Charity Organization Society agent Helen Pendleton, who had first-hand experience of working in the area, was not surprised to note that, as represented on the map, Lower Druid Hill was “so thickly peppered with dots in the colored district that we can scarcely distinguish the names of the streets.”⁶²

Had not viewers been able to “at once recognize the crowded portions and habitations of our colored population,” they would learn to do so in coming years. A contemporary newspaper

⁵⁹ See Roberts, “Infectious Fear: Tuberculosis, Public Health, and the Logic of Race and Illness in Baltimore, Maryland, 1880-1930,” doctoral dissertation, Princeton University Department of History, 2002.

⁶⁰ Addams, “President's address: Charity and Social Justice,” Proceedings of the National Conference of Charities and Corrections 37 (1910), 1-18, quoted in Michael E Teller, The Tuberculosis Movement: A Public Health Campaign in the Progressive Era, New York: Greenwood Press, 1988, 62-63.

⁶¹ Annual Report of the Sub-Department of Health, Department of Public Safety, for the Fiscal Year Ended December 31st, 1903, 1904, 34. Record Group 19, Baltimore City Archives (BCA).

⁶² Helen B. Pendleton, “Negro Dependence in Baltimore,” Charities 15:1 (7 October 1905), 51.

featured in its account of the exposition a section titled "Race as an Element" and noted that, of the 11,582 dots upon the map, there seemed to be an unusual concentration in what it identified as the city's "Lung Block," which was "right in the heart of the negro section, being bounded by Hoffman street, Pennsylvania avenue, Biddle Street and Druid Hill avenue."⁶³ In November 1905, the Baltimore *Sun* reported that, of all the collections to be contributed to an upcoming New York City tuberculosis exposition, the one from Maryland would be the "most complete," featuring among other exhibits "a series of pictures showing the infected districts" such as Baltimore's Lung Block.⁶⁴

After meetings and organizing throughout the year, on 13 December 1904 at McCoy Hall, where the January Exposition had been held, state physicians, nurses, social workers, and philanthropists formed the Maryland Association for the Prevention and Relief of Tuberculosis, electing officers (Dr. Henry Barton Jacobs was made President) and adopting an official constitution. Maryland's State Association was not the first (it was preceded by Ohio's and Connecticut's) but its formation set the stage for a rash of similar organizing efforts. No fewer than fourteen states either founded or significantly reorganized their state tuberculosis associations between 1904 and 1914, and the year 1917 saw the last state in the Union, South Carolina, to form a state tuberculosis association. As a movement, the growth in associations was exponential and followed patterns of professional and social network connections.

Particularly strong city associations (such as New York's; Boston's; Chicago's; New Orleans's;

⁶³ "To Combat Consumption. The Tuberculosis Exposition at McCoy Hall Opened. Governor Warfield Speaks. Many Interesting Displays – Appliances for Fighting the Disease—Startling Data About 'Lung Block'," n.d. no journal title. Henry Barton Jacobs Tuberculosis Scrapbooks, Alan Mason Chesney Archives, Johns Hopkins University.

⁶⁴ "Fine Phthisis State Exhibit. Maryland's Plans for Tuberculosis Meeting," Baltimore *Sun*, 23 November 1905. Henry Barton Jacobs Tuberculosis Scrapbooks, Alan Mason Chesney Archives, Johns Hopkins University.

and St. Louis, Missouri's) gave birth to state associations. In other cases, existing state organizations lent support to the establishment of associations in neighboring states.⁶⁵

The very early local and state associations in the United States tended to concentrate on rational charity and moral uplift. The year 1904, however, marked a decisive turn. Bolstered in their claims to political, not just medical, authority by popular support generated by expositions, state associations more decidedly turned their sights to legislation and self-regulation. This necessarily brought the newly-founded MAPRT to take as its first priority a campaign of public education. The Association's first of many publications was a circular in which the MAPRT made "an appeal for the moral and financial support of the people of the State in the fight to be waged by tuberculosis." By the close of 1908 its traveling exposition had claimed great success, and the MAPRT boasted hundreds of separate public lectures that had transpired on the premises of union halls, civic organizations, public buildings, places of worship, county fairs, settlement houses, public schools, and YMCA and YWCA branches throughout the state under MAPRT sponsorship. Some sixty thousand members of the "working population of the State" received copies of the "Consumptives' Golden Rule Card."⁶⁶

The statewide popular support for the emerging antituberculosis movement and its calls for government involvement in tuberculosis control were reflected in the legislation passed in 1904. The turn toward legislation as a means of confronting the city's tuberculosis problem was the result of a number of trends that had been at play. Leading members of the public health profession in the early twentieth century were, like their counterparts in so many other professions, in the process of consciously re-forming their profession's role in public discourse,

⁶⁵ Teller 1988, 123.

⁶⁶ Report of the Maryland Association for the Prevention and Relief of Tuberculosis, 1907-1908.

constructing their authority on a commitment to scientific inquiry (including a new emphasis on bacteriology), associationalism, and efficiency.⁶⁷ In this regard, the MAPRT emerged, as one historian has noted, as Baltimore's "most successful of the special interest groups"⁶⁸ By 1910, physicians and bacteriologists regularly voiced opinion in lay publications on social policy issues such as prostitution, food purity regulation, housing codes, and residential segregation.

Similarly, leading city public health figures in the early twentieth century felt more comfortable approaching city and state legislators with their recommendations for legislation and requests for increased power in forming policy in the name of public health. Consequently, after 1904 anti-tuberculosis efforts were increasingly likely to reflect the public health community's new prestige among city and state lawmakers.

On 8 April 1904, the Maryland General Assembly was the first state legislative body to pass a tuberculosis registration law, which went into effect on 1 May 1905.⁶⁹ Following the suggestions made by the Tuberculosis Commission, the law required the prompt reporting to the State Board of Health of certain data concerning all individuals in the state known to be affected with pulmonary, laryngeal or generalized tuberculosis. The responsibility of reporting was placed upon physicians, hospitals, dispensaries, schools, reformatories, or any other agency involved with the victim.⁷⁰ Like institutions and certain businesses, private physicians were

⁶⁷ George Rosen, *A History of Public Health*, Baltimore: Johns Hopkins University Press, 1993, 1958.

⁶⁸ Crooks, James Benedict, *Politics and Progress: The Rise of Urban Progressivism in Baltimore, 1895 to 1911*, Baton Rouge: Louisiana State University Press, 1968, 189.

⁶⁹ A Brief Review of the Tuberculosis Campaign 1904 to 1914, Prepared by the State Department of Health for the State Conference on Tuberculosis Called by His Excellency Phillips Lee Goldsborough, December 30th, 1914 and Held at Annapolis, January 22 and 23, 1915, 23.

⁷⁰ Registration consisted of the completion of a form upon which data was to be provided by the physician. Along with general information such as name, address, age, place of birth and residence, the following questions had to be answered:

required to report, but for their effort (which included the distribution of printed information and disposable sputum cups) were paid \$1.00 per patient.⁷¹ The law also required the disinfection of premises occupied by any victim of tuberculosis. Such disinfection could only be executed by, or under the supervision of, the Board of Health.

The 1904 session of the state legislature also expanded police powers in the name of public health. At his address at the Exposition's opening, Dr. William Sydney Thayer, president of the Maryland TB Commission quoted (but left unnamed) "one of the greatest of modern biologists": "As we march onward toward the true goal of existence mankind will lose much of its liberty. . . . The more exact and precise a science becomes the less freedom we have to neglect

_____ *Economic data:* (a) Is the patient engaged in the original occupation? (b) Is the earning power as good as ever? (c) If working irregularly or at reduced wages, how long? (d) If totally disabled, is the patient confined to bed? (e) Consumption in family history?

_____ *General Data:* (a) Number of children living or dead? (b) Are there infants or young children in the house? (c) If the patient is a mother, does she nurse an infant? (d) Does the patient habitually kiss other persons on the mouth? (e) Does the patient use dishes, tableware, pipes, clothing, handkerchiefs, or towels in common with other persons? (f) Does the patient prepare the food of the family?

Disposal of the Sputum: (a) Does the patient spit upon the floor, walls, carpet, or furniture? (b) Does the patient spit into a spittoon used by other persons? (c) Does the patient spit into a handkerchief or into a paper napkin? (d) Into a paper sputum cup? (e) into China, glass, or metal sputum-cup? (f) Is water, carbolic acid, or any disinfectant used in the sputum-cup?

Final Disposal of Sputum: (a) Is sputum burned? (b) Is it thrown into water-closet or sewer? (c) Is it thrown away with garbage or other refuse? (d) Are the patient's handkerchiefs put into the wash with other clothing? (e) Are the patient's handkerchiefs disinfected before being laundered?

Condition of the Room: (a) Is the room suitable in size, heating, and ventilation for a tuberculous person? (b) Are hangings, floor-coverings, and furniture such as admit of proper prophylaxis? (c) How are the walls finished — rough plaster, smooth plaster, wainscoting, papered, painted? (d) Are the walls or furniture ever wiped off with a disinfectant? (e) Is the room swept and dusted in an ordinary way with a feather-duster? (f) Are the floors ever washed with a disinfectant? (g) How many other persons occupy the patient's bedroom? (h) Does anybody share the patient's bed? (i) Is the patient's bedroom used as a kitchen or as a dining-room? (j) Do children play on the floor of the bedroom? See Marshall Langton Price, "The Statutory Control of Tuberculosis with Special Reference to the Maryland System," Volume 4, Part 1, Section 6, Transactions, Sixth International Congress on Tuberculosis, Washington, DC, 28 September - 5 October 1908, Philadelphia, 1908, 214.

⁷¹ On the other hand, any physician failing to execute the duties charged them by the legislature "or who shall willfully make any false statement concerning the name, age, color, sex, address or occupation of any person reported as affected with pulmonary or laryngeal tuberculosis or who shall certify falsely as to any of the precautions taken to prevent the spread of infection" would be charged with fraud, conviction thereof was punishable by a fine of \$100.00, or imprisonment for up to six months, or both. Section 4 of Chapter 399 of the Acts of the Maryland State Legislature, January Session, 1904 (approved 8 April 1904), rpt in Report of the Tuberculosis Commission of Maryland, 1902-1904, Baltimore: Sun Job Printing Office, 1904, 100.

its lessons. . . Certain liberties, such as failure to vaccinate against smallpox, spitting on the floor, and a multitude of others, are worthy of a barbaric past, and must disappear with the progress of civilization.”⁷² Thayer was essentially broadcasting what legislators had assured him was inevitable: the criminalization of certain behaviors. Although public spitting had actually been criminalized by a 1902 law that applied only to railroad platforms and passenger cars, the 1904 session of the state legislature also made it a misdemeanor offense for a tuberculous person to dispose of his or her sputum “or other bodily secretion or excretion as to cause offense or danger to any person or persons occupying the same room or apartment, house or part of a house.” Defined as a nuisance, such behavior could be properly reported to the city or county Health Department for investigation.⁷³ This expansion of the nuisance law specifically reflected the new approach emphasizing the dictum, in Thayer’s words, that “a successful attack on tuberculosis in Maryland must be made largely through the homes of those affected.”⁷⁴ The 1904 legislation specifically addressed the incorrigible consumptive who could not be convinced of the importance of proper prophylaxis. It was the stick to match the carrot of education and public assistance, the recognition, in the words of the law’s author, Dr. Marshall Price, that “legal regulation is the most important of any of the agencies in the fight against tuberculosis.”⁷⁵

⁷² “Remarks on the Occasion of the Opening of the Tuberculosis Exposition in Baltimore on the 25th of January, 1904,” Report of the Tuberculosis Commission of Maryland, 1902-1904, Baltimore: Sun Job Printing Office, 1904.

⁷³ Section 1, Chapter 399 of the 1904 Acts of the General Assembly of Maryland, quoted in Marshall L. Price, “Registration of Tuberculosis,” Journal of the Outdoor Life 6:3 (March 1909), 70; “Remarks on the Occasion of the Opening of the Tuberculosis Exposition in Baltimore on the 25th of January, 1904,” Report of the Tuberculosis Commission of Maryland, 1902-1904, Baltimore: Sun Job Printing Office, 1904.

⁷⁴ Thayer, “Letter of Transmissal of Special Tuberculosis Act,” rpt in Report of the Tuberculosis Commission of Maryland, 1902-1904, Baltimore: Sun Job Printing Office, 1904, 95.

⁷⁵ Price, “Registration of Tuberculosis,” Journal of the Outdoor Life 6:3 (March 1909), 71.

URBAN PLANNING, PUBLIC HEALTH, AND PRODUCTION OF THE GEOGRAPHY OF RACE AND DISEASE

The cartographic identification of the Lung Block initially served the purpose of suggesting conclusions about the location of active cases and some even suggested that these areas posed a threat to the community. The incongruity between this latter speculation and the tenets of house infection, in whose name maps were produced and surveillance was escalated, would have been apparent in a context other than that of the Negro Question, a bundle of social and economic problems that, for whites, concerned the need for policing more than anything else. Despite the fact that Baltimore's Lung Block was, after all, located on the south end of an otherwise socially stable black corridor (which presumably also would have been threatened), it was largely due to its geographic proximity to middle-class *white* households, and the realization that many of its inhabitants worked in white households, that it arose as a public health problem in the short period of time following the first tuberculosis surveys. Baltimore's health professionals and social investigators were more prone to represent the city's black population as performing certain behaviors that put themselves, and others, at risk. In Baltimore's antituberculosis crusade, the Biddle Alley neighborhood and its inhabitants thus emerged by 1904 as principle objects of study and scorn.

Had the city's leaders taken the CHD's tuberculosis maps as a call for action in the city's slums, later events momentarily eclipsed the importance of tuberculosis control. One month after the Tuberculosis Exposition, the Great Fire of February 1904 gutted seventy city blocks and 1,526 buildings in Baltimore's downtown commercial district, instantly and unpredicably presenting the city with its worst economic disaster since the Civil War. As Baltimore's political and civic leaders rallied the city to literally rise from the ashes, the fire served to temporarily end

decades of partisan stalemate surrounding public improvement. In this climate of unheard-of amicability between the two political parties, the General Public Improvements Conference, convened in December 1904, gave representation to most of the city's constituents while excluding African-American leaders. What resulted was a resolution to propose city-wide referenda, passed in May 1905, authorizing loans of ten million, two million, and one million dollars for modern sewerage construction, the paving and widening of streets, and a program of park construction, respectively.

The works ratified by the three referenda offered little amelioration to the overcrowded and deteriorating neighborhoods in which Baltimore's black poor lived, continuing the process of underdevelopment that had begun two decades before, when blacks first began to migrate en masse to Northwest Baltimore. The construction of parks, originally planned by the Olmsted brothers (the sons of Frederick Law Olmsted) in 1902, occurred in accelerated fashion largely in the city's suburbs. Similarly, much of the two million dollars to be raised for infrastructural improvements was reserved for the undeveloped suburban area annexed in 1888, which city officials and planners viewed (and advertised) as the future of Baltimore residential life.⁷⁶ In 1907, the bulk of the city's ongoing construction (some 840 structures) was undertaken in the burned-out downtown business district that perished in the fire of 1904 and in the burgeoning suburbs. Lower Druid Hill would continue to decline in quality of housing while still realizing substantial revenue for its landlords.⁷⁷

⁷⁶ Crooks, 1968, 145-149.

⁷⁷ "Baltimore Has Building Record. Increase in Operations the Greatest in Years," Baltimore American 3 November 1907.

In fact, despite record housing construction of the post-fire years, in its unimproved state Lower Druid Hill throughout the next three decades seemed a vicious atavism from the mid nineteenth century. This was largely because landlords, enjoying a seller's market, were assured high rents from an African-American tenant pool forced into a geographically limited area, and therefore rarely had an incentive to repair dilapidated dwellings. Yet upon the landlords' injury of poorly maintained housing was heaped the insult of municipal neglect. Housing reform of 1908 addressed only tenements, not alley houses. As houses decayed and sanitation went neglected, the result was an immediate environment intensely deleterious to human health. Lower Druid Hill's alleys were notoriously narrow, and with the mounds of uncollected debris and overflowing privies that flooded these alleys, pedestrians traversed at their own peril. Sanborn Company Fire Insurance maps from 1891 and 1914, revealing little change over twenty-three years, show that the narrowest alley in the Lung Block on which houses could be found on both sides (Stone Alley) was approximately eight to ten feet wide.⁷⁸ A housing survey published in 1920 showed that other alleys in the area, "hardly worthy to be called more than passage-ways," yet onto which dwellings faced, were as narrow as five feet.⁷⁹

⁷⁸ Sanborn Company Fire Insurance Company, Inc., Map of Baltimore, 1891 and 1914, Milton S. Eisenhower Library Government Publications and Maps Division, Johns Hopkins University, Baltimore. A housing survey by the Maryland Association for the Prevention and Relief of Tuberculosis describes Stone Alley as being eight feet wide. Maryland Association for the Prevention and Relief of Tuberculosis, "Report on Negro Investigation in Baltimore," Baltimore, ca 1920. Schomburg Center for the Study of Black History and Culture.

⁷⁹ Maryland Association for the Prevention and Relief of Tuberculosis, "Report on Negro Investigation in Baltimore," Baltimore, n.d., ca. 1920, 3. Schomburg Center for the Study of Black History and Culture.

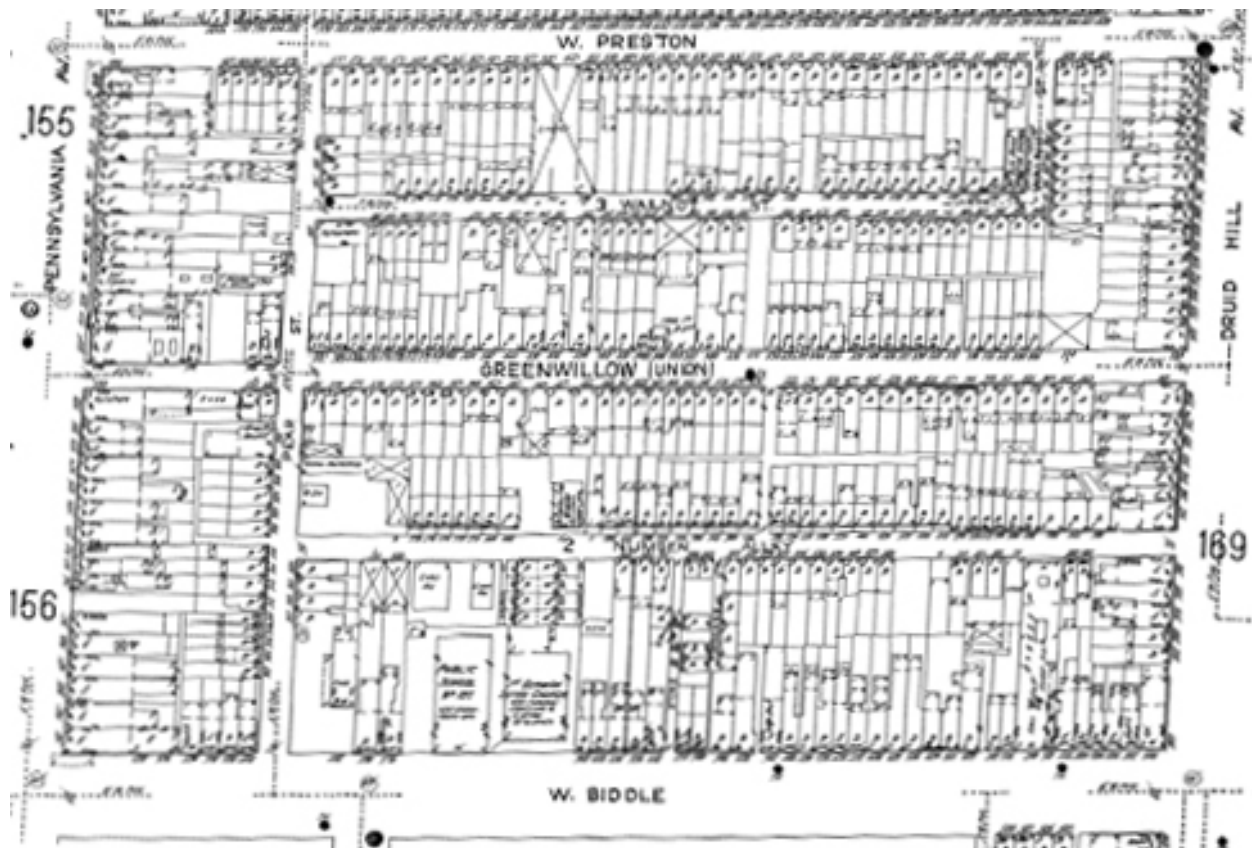


Image 4: section of 1914 Sanborn Fire Insurance Company map showing the area bounded by West Biddle and West Preston Streets and Druid Hill and Pennsylvania Avenues, also known as Baltimore's Lung Block (Milton S. Eisenhower Library, Johns Hopkins University)/

SOCIAL SURVEYS

The Baltimoreans of those days were complacent beyond the ordinary, and agreed with their envious visitors that life in their town was swell. I can't recall ever hearing anyone complain of the fact that there was a great epidemic of typhoid fever every Summer, and a wave of malaria every Autumn, and more than a scattering of smallpox, especially among the colored folk in the alleys, every Winter. Spring, indeed, was

*the only season free from serious pestilence, and in Spring the communal laying off of heavy woolen underwear was always followed by an epidemic of colds.*⁸⁰

Mencken's recollection that Baltimoreans thought of their town as "swell" while suffering malaria and typhoid is only somewhat ironic. Disease before the late nineteenth century was more to be endured than combated. Modern public health was reborn in the age of Progressivism and, as part of the social and intellectual milieu, helped to thereafter reshape urban consciousness. Viewing the emergence of urban industrial capitalism, its participants increasingly viewed the terrain of the city as a system of overlaid matrices of work, leisure, consumption, and disease.⁸¹ It was this view that gave rise to the social survey and the new consciousness of space it inaugurated. The social survey, like the World Exhibition, was transatlantic, but shaped in the United States by local political economy.⁸² Although post-1930 empirical sociology would choose to forget the social survey, there was no denying its impact.

⁸⁰ H.L. Mencken, Happy Days, New York: Alfred A. Knopf, 1940, 63.

⁸¹ David Harvey, The Urban Experience, Baltimore, MD: Johns Hopkins University Press, 1985; Ira Katznelson, Marxism and the City, New York: Oxford University Press, 1992.

⁸² Jean M. Converse, Survey Research in the United States: Roots and Emergence, 1890-1960, Berkeley: University of California Press, 1987; Martin Bulmer, Kevin Bales, and Kathryn Kish Sklar, "The social survey in historical perspective," in Bulmer, Bales, and Sklar, eds., The social survey in historical perspective, 1880-1940, New York: Cambridge University Press, 1991, 1-48; Eileen Janes Yeo, "The social survey in social perspective, 1830-1930," in Bulmer, Bales, and Sklar, eds., The social survey in historical perspective, 1880-1940, New York: Cambridge University Press, 1991, 49-65; Jennifer Platt, "Anglo-American contacts in the development of research methods before 1945," in Bulmer, Bales, and Sklar, eds., The social survey in historical perspective, 1880-1940, New York: Cambridge University Press, 1991, 49-65; Daniel T. Rodgers, Atlantic Crossings: Social Politics in a Progressive Age, Cambridge, MA: Belknap Press of Harvard University Press, 1998. See also Roy Lubove, The Progressives and the Slums: Tenement House Reform in New York City, 1890-1917, Pittsburg: University of Pittsburgh Press, 1962; David Ward, "The Progressives and the Urban Question: British and American responses to the Inner City Slums 1880-1920," Transactions of the Institute of British Geographers 9 (1984), 299-314 Martin Bulmer, Kevin Bales, and Kathryn Kish Sklar, eds., The Social Survey in Historical Perspective, 1880-1940, Cambridge ; New York: Cambridge University Press, 1991; Rolf Lindner, The Reportage Of Urban Culture: Robert Park And The Chicago School, trans. Adrian Morris, New York: Cambridge University Press, 1996; Michael B. Katz, and Thomas J. Sugrue, eds., W.E.B. Du Bois, Race, and the City: The Philadelphia Negro and Its Legacy, Philadelphia: University of Pennsylvania Press, 1998.

Mencken wrote with far too much tongue in his cheek for us to regard his reminiscences as revealing anything of Baltimore consciousness(es) of disease or comfort, but it is nonetheless true that, by 1940 the survey had made its mark. It had become authoritative yet popular, definitive in its claims yet always demanding more study. By the time evidence of the decline of the social survey appeared in the early 1930s, as Martin Bulmer reminds us, there had been over 2,000 social surveys conducted in the United States. The state of Maryland again revealed itself a border state in more than geography. More social surveys were conducted there than in most other Southern states, but not nearly as many as in New York, Pennsylvania, Massachusetts, New Jersey, or Ohio⁸³ Surveys made the city “known” not only to those who read them, but to those who read about them in newspaper and journal accounts. It was from this vantage that Mencken offered his recollections. Left neglected by uneven development, Baltimore's black-occupied alleys were not much traversed by commerce and were not frequently visited by many outsiders. Yet if Mencken could in the mid-twentieth century remember a general awareness among all the city of a “scattering of smallpox, especially among the colored folk in the alleys” every winter, it was likely because he, too, forgot that that the social survey had created such a consciousness.

Two years after the Exposition and the great fire, the city returned to the matter of the geographical contours of health. In March 1906 the city Police Department conducted a city-wide Health Census, information from which was used in planning public health work in Baltimore. Although Johns Hopkins Hospital and the City Health Department had conducted a

⁸³ Martin Bulmer, “The Decline of the Social Survey Movement and the Rise of American Empirical Sociology,” in Bulmer, Bales, and Sklar, eds., *The Social Survey in Historical Perspective, 1880-1940*, New York: Cambridge University Press, 1991, 291-315; Allen H. Eaton and Shelby M. Harrison, *A Bibliography of Social Surveys; Reports of Fact-Finding Studies Made as a Basis for Social Action; Arranged by Subjects and Localities; Reports to January 1, 1928*, New York: Russell Sage foundation, 1930.

number of neighborhood-oriented surveys, varying in methodological rigor, the Police Health Census of 1906 was the first such study to consider the entire city and its health. As a consequence, the methods involved were, in the words of Health Commissioner James Bosley, “somewhat crude and perhaps lacking in accuracy in some details.” For example, without the aid of previously established health districts (“health units” or “area units”), the Police Department had to take the “sufficiently fixed” boundaries of the political ward as units of geographical analysis. Wards were constructed for political, not public health, purposes, and the people within a ward were not always a homogenous group in their class composition or ethnic identification. There could exist within a ward “a vast difference in the people in their environment and financial status.” Even political precincts, several of which comprised a single ward, were insufficient for the purpose of accurately determining the geographic distribution of health conditions.

Nevertheless, taken in its entirety, the 1906 Health Census confirmed many of the impressions that health officials had formed over the years and provided enough information for CHD officials to formulate future policy.⁸⁴ It showed wide variation in death rates between wards, ranging from as low as 13.37 per 1,000 in the Eighth Ward to as high as 29.207 per 1,000 in the Fourth Ward. Acknowledging that “every ward will require special study,” Commissioner Bosley charged officers of the CHD with the duty of having a “thorough acquaintance with all local and general conditions that are commonly considered as factors”, including water supply, milk supply, age distribution of the population, quality and character of housing stock, and population density. In the meantime, Bosley ventured an explanation for the high death rate in

⁸⁴ Annual Report of the Sub-Department of Health, Department of Public Safety, for the Fiscal Year Ended December 31st, 1906, (1907), 49-50. RG19, BCA.

the Fourth and Fourteenth Wards, hypothesizing that in the Fourth Ward, many of the deaths there could be attributed to the presence of St. Elizabeth's Home for Colored Infants, "a large number of bawdy houses", "a large proportion of the drifting, shiftless population", and "probably a greater number of suicides." That the Fourteenth Ward was home to St. Vincent's Infant Asylum and "a large number of colored people" made it liable to elevated death rates. Conversely, Bosley was surprised to see "the poor showing made by the Eleventh Ward, where there are so many of our wealthy people," but ascribed the elevated mortality there to the ward's relatively large number (6,973) of African Americans who ironically seemed to be "under more unfavorable conditions than [blacks] in the Fourteenth or Seventeenth."⁸⁵

The "thorough acquaintance" that Bosley advised was to be desired by not just health officers, but also by charity workers, who were charged with a similar task: the assessment of social and domestic conditions. One year after the Health Census, and six years after health officials first brought Lower Druid Hill to public attention, the city's first survey that dealt specifically, though not exclusively, with the Biddle Alley district emerged not from the public health sector, but from the collaboration of Baltimore's two major social work organizations: the Association for the Improvement of the Condition of the Poor (AICP), and the Charity Organization Society of Baltimore (COS). Janet Kemp's Housing Conditions in Baltimore was an investigation into the living environment of four neighborhoods in Baltimore — the Albemarle Street district, the Thames Street district, the Hughes Street district, and the Biddle Alley district. The Albemarle Street and Thames Street districts were both tenement districts, occupied almost entirely by immigrants or their native-born progeny. The Hughes Street district

⁸⁵ Ibid., 49.

and the Biddle Alley district were both alley districts and predominantly black. Presented with a series of photographs, tables, and maps, Kemp's survey was written in the tradition and vernacular of the genre. The influences on Kemp's work were apparent. From the United States's E. R. L. Gould she took her definition of overcrowding (measured by persons per room, not persons per acre). In assessing the problem of housing construction and the social causes of poverty, she consciously adopted the methods developed by English businessman and social reformer Seebohm Rowntree in his study of York, England (1901).⁸⁶ Nearly one hundred pages and including several leafs of maps and tables, Kemp's study quickly realized national recognition, and its author was later commissioned to conduct a similar survey for the Louisville, Kentucky Tenement House Commission.⁸⁷

In Biddle Alley, located in the Seventeenth Ward, Janet Kemp was negatively impressed with the state of alley houses, which were particularly poor in quality, although structurally similar dwellings of better quality could be found throughout the older parts of the city. Many of Biddle Alley's houses had been constructed in the late eighteenth century, or had been since built upon lots carved out of larger properties or back yards. Opening on alleys, and not public streets, the entire area upon which an alley house fronted was privately owned by the landlords on either

⁸⁶ E.R.L. Gould, "The Housing of the Working People" (Eighth Special Report of the United States Commissioner of Labor), 1895; B. Seebohm Rowntree, Poverty: a Study of Town Life, London, New York, : Macmillan, 1901. Although Kemp made no reference to Du Bois's The Philadelphia Negro, a social survey conducted by the Maryland Association for the Prevention and Relief of Tuberculosis around 1920s noted that Kemp, "being acquainted with the successful use of a set of questions used by Dr. Dubois [sic] in his studies of the Philadelphia colored people, and believing this schedule would comprise all the inquiries necessary for an insight into the social life of the Baltimore colored people," adopted Du Bois's schedule "practically unchanged." Maryland Association for the Prevention and Relief of Tuberculosis, "Report on Negro Investigation in Baltimore," Baltimore, ca 1920, 21-2. Schomburg Center for the Study of Black History and Culture.

⁸⁷ Janet Kemp, Report of the Tenement House Commission of Louisville, under the ordinance of February 16, 1909, Louisville, 1909.

side of the alley. Thus the houses infrequently enjoyed the benefits of street cleaning, and in many the only means of cleaning were rain showers and the scavenging of local swine.⁸⁸

The problems of narrow alleys were compounded by the lack of drainage and sewerage. Although piecemeal sewerage construction had begun in the early twentieth century, well into the 1920s, none of the houses in the Biddle Alley neighborhood possessed an adequate water supply or sewerage. What had to suffice was an arrangement in which several houses or apartments would share one hydrant and one or two privies, both of which usually overflowed into the alley and seeped into basements where people could be found sleeping, eating, and cooking. Fortunately, the majority of the area's residents lived above ground, but all of them would have been more fortunate to have grown wings, since pedestrians were forced to negotiate the fjord-like collections of sludge, risking the possibility of "stepping in the filth which is more than ankle deep in most places."⁸⁹ So bad was surface drainage in Lower Druid Hill that more cynical Baltimoreans referred to it as "honey-combed with springs."⁹⁰

Kemp's survey was in fact impressive, but the veneer of scientifically detached investigation masked methodological flaws that ultimately revealed its author's biases. It was apparent that Kemp was more interested in the study and reform of tenement districts – inhabited mostly by whites and European immigrants – than in the alley districts where most of the city's black poor resided. In many cases, to compensate for these flaws, Kemp fell back on stereotype and moralism. Kemp acknowledged Seebohm Rowntree's admonition that it was persons per

⁸⁸ William Travis Howard, *Public Health Administration and the Natural History of Disease in Baltimore, Maryland, 1797-1920*, Washington, D.C.: Carnegie Institution, 1924, 25, 26, 118.

⁸⁹ Approximately three quarters of the buildings in the area had basement rooms used as living or cooking quarters. Maryland Association for the Prevention and Relief of Tuberculosis, "Report on Negro Investigation in Baltimore," Baltimore, n.d., ca. 1920, 4, 12. Schomburg Center for Research in Black Culture, New York City.

⁹⁰ Kemp 1907, 38.

room, not per acre, that was most important in studying housing conditions, and dutifully noted that overcrowding in this regard was particularly acute in the tenements, carefully tabulating persons-per-room ratios for the tenement districts. She completely failed, however, to do so for the alley districts. As a rationalization, she offered that, "owing to the irregular life and habits of a large proportion of the people in these districts," and the alleged habit of young black women in particular who "lived up, or rather down, to the prevailing alley standards," blacks elected overcrowding in order to live with erstwhile mates who became "more or less permanent residents." Therefore any information given by alley residents about the number of people living in a house would have to be deemed "entirely untrustworthy," making it "a waste of time to tabulate these statements." Kemp hypothesized that "nothing but a night inspection," which she apparently was unwilling to conduct, would yield an accurate picture of "the overcrowding which undoubtedly exists in these districts."⁹¹

Most strikingly absent from Kemp's analysis was an investigation of income and economic situation. Of residents in the two tenement districts (native-born whites and European immigrants) we know that laborers and garment workers collectively made up 44% of the heads of families. No such tabulation did she perform in the alley districts, however. Census returns for 1900 and 1910 show a high proportion of full-time and occasionally- or seasonally-employed laborers and domestic servants and laundresses (all of whom were paid less than immigrants and native-born whites for the same work) in the Biddle Alley district, where, as Kemp did note,

⁹¹ Kemp 1907, 43.

rents were the highest and paid in exchange for lesser accommodations than those enjoyed by tenement dwellers.⁹²

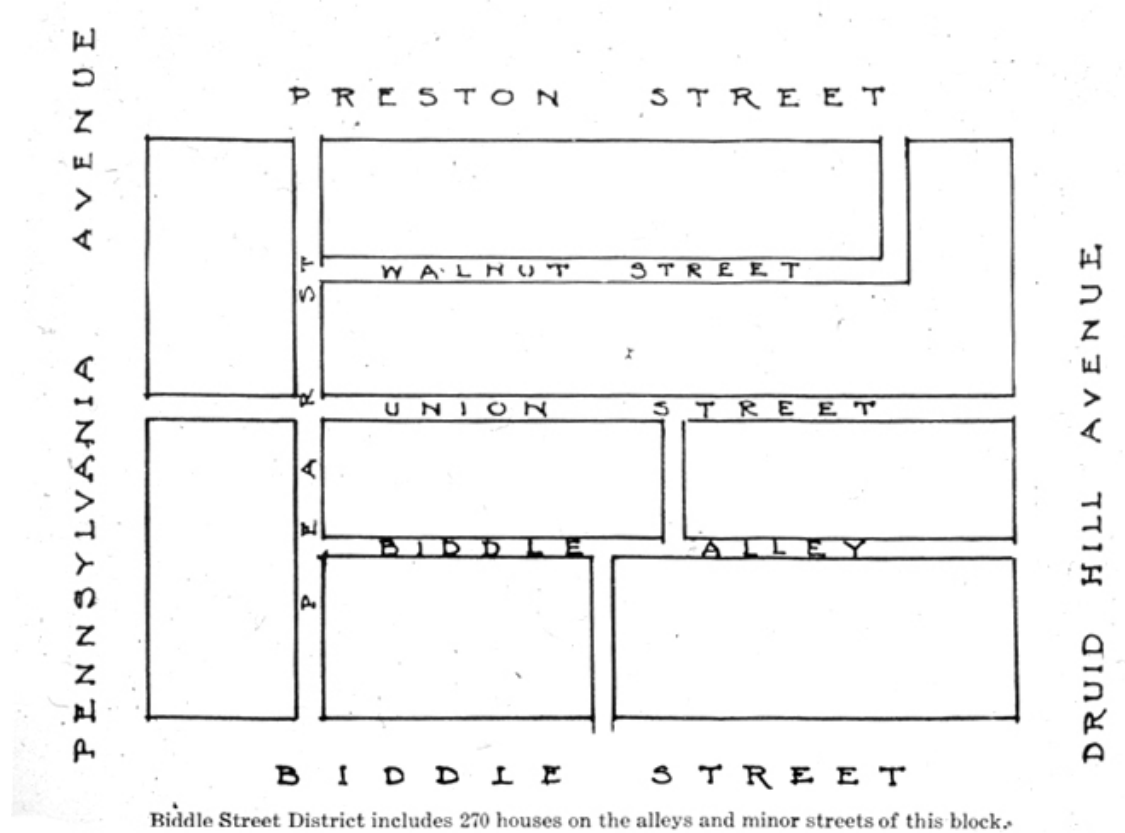


Image 1: Map captioned, “Biddle Street District includes 270 houses on the alleys and minor streets of this block.” Janet Kemp, Housing Conditions in Baltimore: Report of a Special Committee of the Association for the Improvement of the Condition of the Poor and the Charity Organization Society, Baltimore: The Federated Charities, 1907. Special Collections of the Milton S. Eisenhower Library, Johns Hopkins University.

Had Kemp been willing to investigate the economic origins of overcrowding, she might have determined that lower pay and higher rent provided an incentive for non-familial cohabitation above simple affection. Certainly this should have occurred to her, since the relationship between income, poverty, and housing was a central theme in Sebohm Rowntree’s

⁹² Kemp 1907, 82.

work, after which Kemp partially modeled, but only selectively, her own survey. Kemp was hardly alone in turning the Atlantic Ocean into a filter through which more class-oriented aspects of social science and politics could not pass, as Daniel Rodgers has shown most recently.⁹³ In this case, in the absence of economic considerations was left a methodological vacuum in which Kemp could make moralistic, *racial*, pronouncements. In fact, although hers was ostensibly “not a study of social conditions,” housing conditions led Kemp into lengthy discussions devoted to her perceptions of the relation between culture, morality, domestic hygiene, and environment. In the rapid ethnic transition in Biddle Alley from white to black Kemp claimed to have observed a similar change in the general work ethic that pervaded the area. Biddle Alley, “occupied largely by negroes with a sprinkling of native white families,” by 1907 could claim only “a remnant of the colony of clean, hard-working, thrifty Germans, who seem to have constituted the original inhabitants.” In the Biddle Alley district in particular, there was “abundant evidence of failings more serious than improvidence and irresponsibility,” such as alcoholism, gambling, sporadic violence, cocaine abuse, and family disorganization. Among black alley residents, Kemp claimed there was “what appears to be in many cases an entirely undeveloped moral sense, especially as regards the relation between the sexes,” and that many alley dwellers had “reached the bottom level of degeneracy.”⁹⁴

Turning a blind, or at least myopic, eye to the economics of white supremacy, social workers and investigators (among whose ranks we may naturally include visiting nurses) were often at a loss to describe the root causes of what they considered to be lax moral and hygienic

⁹³ Daniel T. Rodgers, *Atlantic Crossings: Social Politics in a Progressive Age*, Cambridge, MA: Belknap Press of Harvard University Press, 1998.

⁹⁴ Janet E. Kemp, *Housing Conditions in Baltimore*, 1907.

conditions in Biddle Alley. In her befuddlement, Janet Kemp borrowed the metaphor of soil-and-seed – hygienic and *moral* conditions in Biddle Alley necessarily “must offer congenial soil for the propagation of disease germs” – modifying its most recent epidemiological connotations (the soil of physiological predisposition combined with the seed of the causative agent) to include the social. Neglect on the part of landlords and the city could be blamed for some of the conditions in Baltimore's alleys, but “low standards and the absence of ideals cannot fail to be held in some degree accountable for the squalor and wretchedness.” “It is impossible to observe these gregarious, light-hearted, shiftless, irresponsible alley dwellers,” she recalled, “without wondering to what extent their failings are the result of their surroundings, and to what extent the inhabitants, in turn react for evil upon their environment.”

Indeed, Kemp had worked closely with the City Health Department and the Maryland Association for the Prevention and Relief of Tuberculosis, representatives of the professional sector most responsible for the popularization of the soil-and-seed metaphor and the image of the Lung Block, and had been briefed before conducting her study on Biddle Alley's infamy as a center of tuberculosis infection. This clearly marked the intellectual exchange between social work and public health, and Kemp, probably at Maryland health officials' direction, noted Britain's George Reid, whose Practical Sanitation had made a positive correlation between tuberculosis incidence and the degree of dampness that Kemp found in seventy-four percent of Biddle Alley's cellar apartments. In the very same paragraph, however, Kemp raised the Atlantic filter: “It must also be taken into consideration that most of the inhabitants of the district are negroes who live from the cradle to the grave in colossal ignorance and disregard of every

known law of hygiene.”⁹⁵ As an example, Kemp elsewhere in the report claimed that “among the negroes it is considered unlucky to continue to use the bed upon which a member of the family has died,” and that many discarded, bacillus-ridden, mattresses could be found in cellars.⁹⁶

In fact, because municipal sanitary services in the alley districts were at best poor, it is entirely possible that the cellar would have served as the only disposal ground for bedding known to be contaminated, but which, if left outside of the house, was more likely to draw a nuisance fine than the attention of garbage collection. Kemp did recommend that the city more vigilantly execute the duty of sanitation in the alley districts, but made little other comment otherwise as to how the alley problem could be addressed. The bulk of her other recommendations – dealing with structural height; establishment of modern emergency fire egress regulations; registration of structures; light and ventilation regulations; and a two-room minimum per apartment – all applied exclusively to tenements, where most of Baltimore's white poor lived, not alley dwellings, which housed the city's black poor. In fact, the beginning and the end of her report provided a lengthy discussion of the inadequacy of the currently used definition of the term “tenement,” and called for a more modern version to include the newer forms that had appeared over the last twenty years. No such calls for redefinition did Kemp make for alley houses, and her second recommendation for alleys in this regard only called for a more extensive exercise of the city's power of condemnation. Alley houses would either stand or fall, but the eventuality of the latter case occasioned no anticipation on Kemp's part of the

⁹⁵ George Reid, *Practical sanitation; a handbook for sanitary inspectors with an appendix on sanitary law by Herbert Manley*. 11th ed, London, 1904; Kemp 1907, 71.

⁹⁶ Kemp, 1907, 47-8.

need for replacement housing. Although with approbation she pointed to housing reclamation work in London inspired by Octavia Hill, and cited health reports from Liverpool, England, that showed that the replacement of slums with model tenements reduced the death rate, Kemp did so only in the midst of her discussion of the tenement, not alley house, problem. This, despite Kemp's acknowledgement that the Biddle Alley and the Hughes Street districts' houses were in a poorer state of repair than those found in the tenement districts.⁹⁷

COUNTERNARRATIVES OF GEOGRAPHY

In a special 1905 issue, on “The Negro in the Cities of the North”, of Charities and the Commons (a national journal of social work and philanthropy) appeared two articles featuring Baltimore. Charity Organization Society Agent Helen Pendleton's “Negro Dependence in Baltimore” was a scathing indictment of supposed black social disorganization, idleness, ignorance, and perfidy. In “Some Causes of Criminality Among Colored People,” however, black physician Dr. James Waring offered a different view. Waring was principal of the Colored High School and had practiced medicine for twenty-seven years, serving black communities in Baltimore and Washington, DC. As such, he was well qualified to discuss the social problem of the “alley home,” the surroundings of which he believed were one cause of black social disorganization. Foreshadowing his work – one year later – challenging the corruption of Baltimore's law enforcement, Waring observed that the city's alleys, “secluded from the officers of the law in particular and the people of the community in general,” served as “the natural

⁹⁷ Only 58% of Biddle Alley's 972 rooms were judged as in good repair; and only 22% of the 437 in the Hughes Street district were not “in a more or less dilapidated condition.” Kemp 1907, 53, 92. See also Octavia Hill, Homes of the London poor, London: Macmillan, 1875; Daniel Rodgers, Atlantic Crossings, 160-208.

rendezvous of the lawless, the vicious, the immoral”, the home of “indecent conduct of every kind and profanity indescribable.” Yet Waring’s critique was not limited to the individual behavior of alley residents. That “few of these alleys, many of which are not over ten feet wide, are fit for habitations”, was largely the fault of unscrupulous landlords. He thus called into question “the conscience of the American people” that “ignor[ed] the fact that little children” were “compelled to live. . . [where] sunlight, pure air, pure thoughts, chaste conduct and associates. . . are denied them from their very birth”.⁹⁸

Between 1906 and 1908, an exclusively male group of prominent black lawyers, physicians, ministers, businessmen, and educators set out to study and address the moral problems of black Baltimoreans, producing a report one year after Janet Kemp’s survey was published. The methods of the Colored Law and Order League, as they called themselves, were somewhat different from Kemp’s. Kemp was a professional, paid by the city’s two major charity organizations. In the very early twentieth century, few organizations would have commissioned black social workers or social scientists to perform a survey (W. E. B. DuBois’s *The Philadelphia Negro* of 1899 being the most notable exception), and the League’s members were untrained in social investigation and undertook their work without compensation other than the considerable social and political capital that accrued from exhibiting civic consciousness. Waring’s report on the League’s behalf therefore lacked data produced from scientific study. It did include original maps, but much of the data was gleaned from other sources.

In the very early twentieth century, few organizations would have commissioned black social workers or social scientists to perform a survey, W. E. B. DuBois’s *The Philadelphia*

⁹⁸ Waring, “Some Causes of Criminality Among Colored People,” *Charities* 15:1 (October 7, 1905), 46.

Negro (1899), being the most notable exception. Perhaps more important, the differences between the League and Kemp were gendered. Before the 1920s, American social surveys were largely the domain of women. From their positions in social settlements and acting simultaneously as members and students of domestic life, women (almost exclusively white) could produce surveys that revealed characteristics of family status and housing conditions. This was in contrast to the enterprise as it was practiced in Britain and, as Mary Jo Deegan has argued, was typical of the era before the 1920s, after which time patriarchalism distinctly marked American sociology.⁹⁹ In their health activism, black women, though politically active, typically emphasized domestic education, largely because of their social position – as black women they were found themselves the object double discrimination, a matter I explore later. Matters of “law and order” and “citizenship” however, seem to have been the sole province of men. The men of the Colored Law and Order League of Baltimore (at first a handful, but soon growing to around one hundred members) identified themselves as “representative colored men of Baltimore” and their purpose as the improvement of “the moral, economic and home conditions among the colored people, and to do whatever would promote good citizenship.”¹⁰⁰

The League's emphasis on the public sphere was literally revealed in their apparent aversion to study of the interiors of homes – there is no evidence that they contemplated a systematic study of domestic life. Members of the League conducted tours of a number of black neighborhoods in the city, paying especial attention to sanitary, moral, and school conditions, focusing in particular on Biddle Alley, where conditions were the worst. Arguing that moral

⁹⁹ Deegan, Mary Jo. *Race, Hull-House, and the University of Chicago: A New Conscience against Ancient Evils*, Westport, Conn.: Praeger, 2002.

¹⁰⁰ James H.N. Waring, *Work of the Colored Law and Order League, Baltimore, Md.*, Cheyney, PA: Committee of Twelve for the Advancement of the Interests of the Negro Race, 1908 , 18.

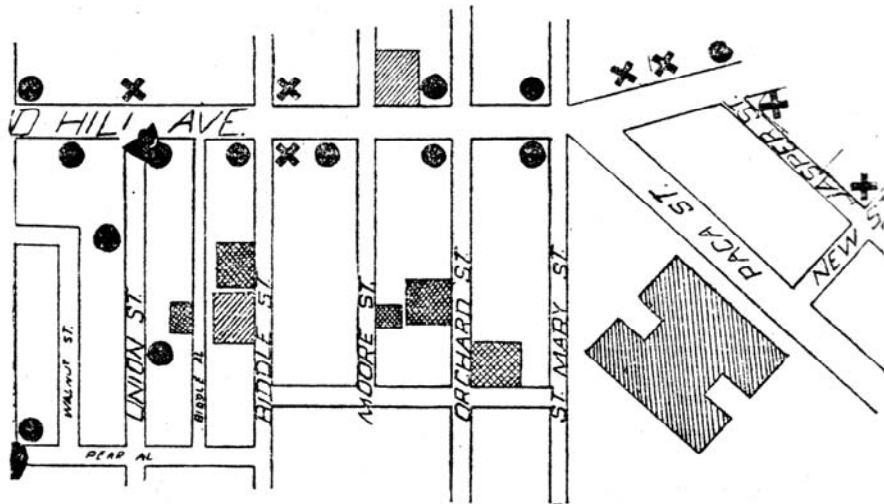
conditions in lower Druid Hill were in large part the result of white influence and police corruption, James Waring, who authored the League's report, noted that saloons, houses of prostitution, and gambling dens operated "principally by white men of the lowest type," often flourished as "the meeting places of the idle, loafing element among the colored people, of the crap shooters, of dissolute women" in close proximity to African-American schools (and even one orphanage) and were thereby "exercising a demoralizing effect upon the colored youth and furnishing schools of crime for colored children." Invoking the low moral ground on which interracial mixing was believed to have often occurred, the League noted that "the saloon which is kept by a white man for colored trade. . . is usually the lowest possible type of saloon."¹⁰¹

In this regard, the League's conclusions differed from those at which whites had arrived, and the League offered an alternative geographical interpretation. As in Kemp's report, the League's report featured maps (six of them). The first map, "Showing Location of Saloons" in the Biddle Alley district, revealed that the area (two square blocks fractured by alleys) was home to six saloons, all owned by white men who, impervious to registered complaints by the community, seemed to enjoy some sort of police protection. The following four maps included three that revealed an incredible density of saloons and disorderly houses in black neighborhoods surrounding Rogers Avenue (on which was located a colored public school); Caroline Street (on which was located another); and Orchard Street (on which was located a third). Another map showed a "poor white neighborhood," around Market Street, which had an equal density of saloons (disorderly houses were not shown).

¹⁰¹ James H.N. Waring, Work of the Colored Law and Order League, Baltimore, Md., Cheyney, Pa: Committee of Twelve for the Advancement of the Interests of the Negro Race, 1908, 3, 10.

MAP
SHOWING
LOCATION OF SALOONS

- SALOONS conducted by WHITE MEN.
- ✕ " COLORED "
- ▨ SCHOOLS
- ▩ CHURCHES.



A map of the lower Druid Hill Avenue District. In this district there were forty-two saloons, fifteen churches, twelve schools, one home for old people, one home for friendless children, the colored Y. M. C. A. and the colored Y. W. C. A.

Figure 5: "Map Showing Location of Saloons," in James H.N. Waring, Work of the Colored Law and Order League, Baltimore, Md., Cheyney, PA: Committee of Twelve for the Advancement of the Interests of the Negro Race, 1908. Most of the Biddle Alley district is shown at the left (northwestern) side of the map, bounded by Biddle Street, Druid Hill Avenue, and Pear Alley. In that section there were six saloons, all owned by whites.

The sixth map was reproduced from a section of the tuberculosis spot map compiled by Drs. Lillian Welsh and Mary Sherwood in 1900 and furnished by the CHD. The section showed the "Druid Hill Avenue District", with the caption, "This is the tuberculosis center of Maryland

and the City of Baltimore.”¹⁰² On the following, opposite, page Waring quoted Janet Kemp's report at length, highlighting her observations regarding public drunkenness, gambling, and other vices. Yet, focusing on law and order, the League offered a different interpretation of the same map that whites for the past ten years had often used to show African-American moral decay. The League report cited the “prevalence of disease, particularly tuberculosis,” along with “bad sanitary conditions” and “bad moral conditions,” as evidence of the deleterious effects of the saloons and disorderly houses. Yet it more strongly than Kemp made the case that the same predatory self interest that trafficked in vice also profited from lax housing regulations that permitted the charge of high rents for residences which were barely habitable.

Alarmed by what they discovered, the League embarked on a reform campaign that showed a masterful navigation of the political waters. Recognizing “the absolute dependence of the colored people generally upon the mercies of the whites,” the formidable influence of “the powerful saloon interests,” and the likely failure of a campaign conducted entirely by blacks (even upstanding black men) the League solicited the cooperation of the city's white leadership. They arranged a meeting with their white male counterparts, including among others, former President of Johns Hopkins University Dr. Daniel Coit Gilman, the president of the Baltimore Chamber of Commerce, the U.S. District Attorney, local philanthropist and Secretary of the Sage Foundation John M. Glenn, Judge Alfred S. Niles of the Supreme Bench of Baltimore City, and “retired capitalist” Isaac Cate.

This group of the city's leading white men met them with a host of questions testing the validity of the League's allegations. They inquired “as to why the colored man will not work”

¹⁰² Ibid. 8.

and “intimated that in some cases the conditions of vice and immorality grew out of the laziness and idleness” of Biddle Alley residents, implying, as had Kemp, that a focus upon environment may be somewhat misdirected. In particular, they had questions regarding the “immorality among colored women and girls.” The matter of the supposed lack of “home life among the colored people”, discussed at length in Janet Kemp’s 1907 report, was also brought up. In the end, the high prevalence of incarceration among blacks seemed to testify to blacks’ generally low morality.

The League was well prepared to respond to these concerns. They admitted that low morals seemed to pervade Lower Druid Hill, but showed their charts and photographs of the areas around saloons and schools, and asked whether even the most pious could go unaffected by such a dissipating environment. The delegation also informed their audience that the most recent Census Bureau data showed that in Maryland black men were employed at a higher rate than white men, disproving allegations of black idleness. With pride they pointed out that the area’s Colored High School, in its twenty-five years of operation, had furnished only one graduate to the state’s penal system. Yet a number of disreputable establishments were allowed to exist nearby to it and other institutions, effectively “furnishing schools of crime for colored children.” This presented another significant departure from the methods Kemp had employed – whereas Kemp was uninterested in the occupations of black Baltimoreans, the League believed this to be of utmost importance.¹⁰³

¹⁰³ The delegates also pointed to the migration of blacks from south and east Baltimore to the northwest corridor, “particularly upper Druid Hill” (as opposed to lower Druid Hill), as evidence of “an upward movement” of the black population and the “growth of the home spirit”. This response in particular pragmatically elided the fact that many of these families had been forced out of south and east Baltimore by the segregationist real estate market and the demolition of black neighborhoods to make way for the construction of Camden Station in the late



Figure 6: "The [Lower] Druid Hill Avenue District. . . This is the tuberculosis center of Maryland and the City of Baltimore," from a segment of a tuberculosis mortality map produced in 1901, reproduced in James H.N. Waring, Work of the Colored Law and Order League, Baltimore, Md., Cheyney, PA: Committee of Twelve for the Advancement of the Interests of the Negro Race, 1908.

These were all matters of law and order, and the League clearly stated what they viewed to be the connection between racial violence and moral uplift of the black community, yet slyly redirected typical indictments of black promiscuity and intemperance toward white saloon owners and landlords. Reflecting upon the recent Atlanta Riot of 1906, they warned that

nineteenth century. Ibid, 14; Sherry H. Olson, Baltimore: The Building of an American City, Baltimore: Johns Hopkins University Press, 1997 (Revised and expanded edition), 276.

Baltimore teetered on the precipice of similar catastrophe. It was true, thankfully, that Baltimore lacked an “incendiary press to inflame the passions of the poor whites,” such as that which existed in Atlanta. Paying tribute to the white womanhood and manhood of Maryland’s principal city, the League also remarked that in the city was absent “a class of hysterical women to take fright at the sudden appearance of a black face,” nor did there exist “that loose attitude toward law and order” that led to the formation of mobs. They noted with chagrin, however, that all but eight of the forty-five or more saloons in Lower Druid Hill were operated by “white men of the lowest type” who had no investment whatsoever in the moral uplift of the colored race. The Baltimore Colored Law and Order League thus shrewdly linked its appeal for police action against white slum lords and proprietors of vice to the interests of civil order and racial harmony, suggesting that the Atlanta Riot may well have been avoided had white leaders there heeded the complaints of black Atlantans.

By paying such tribute and tightly circumscribing the extent to which they would criticize segregation and white supremacy, the Law and Order League was able to garner wide support from Baltimore’s white elite. The resulting hearing before the Liquor License Board on 22 April 1908 attracted a standing-room only crowd, with several of the city’s constituencies represented. The Charity Organization Society submitted data showing that the highest concentration of applications for relief came from Biddle Alley. Former Mayor Ferdinand Latrobe, Attorney General Charles Bonaparte, and William Paret, Bishop of Maryland, all sent to the court letters in support of the League.

The League also received the support of some rather unlikely allies, including the Presbyterian, Congregational and Reformed Association of Baltimore, several of whose more prominent members were ex-Confederate soldiers or chaplains. At the same time, white

property holders living in the area of the intersection of Druid Hill Avenue and McCulloh Street, who nervously looked two blocks west to Lower Druid Hill, were less concerned with the moral uplift of their black neighbors and more interested in the reclamation and enhancement by whites of “millions of dollars in real estate.” This could be done principally by withholding liquor licenses to area saloons and by maintaining racial residential segregation. They submitted a petition “applaud[ing] the efforts of the colored ministers and others of their race”, but expressed their resentment at the “invasion” of their neighborhood by any blacks at all. The League’s campaign appeared to them to complement their own agenda of halting at Druid Hill Avenue the encroachment of blacks into white territory.¹⁰⁴

In the end, only eleven saloons were denied license renewal. The effect of the hearings, however, was greater than the reduction of saloons in Lower Druid Hill. Because so many officers and detectives had testified that all the saloons there were orderly and operating within the law, the avalanche of evidence to the contrary impugned the integrity of the entire precinct. It had become clear not only that many officers were corrupt and welcoming of bribes, but that a number had perjured themselves at the hearings. Journalistic coverage by the Baltimore News and the American emphasized the reform spirit of the anti-vice alliance and roundly condemned the police force, whose leadership was entirely replaced on 1 May 1908 with men whose approach to law enforcement was more in keeping with the good government sentiments that had entered public consciousness since the political reforms of the mid-1890s.

The League’s crusade certainly changed the political landscape of Baltimore, but the physical landscape of Lower Druid Hill was not substantially altered. During the League’s

¹⁰⁴ Ibid, 22, 23.

campaign, reformers repeatedly made references to the unsanitary conditions of Lower Druid Hill, but usually in connection with the area's moral environment, and no housing reform would result. The Baltimore American howled that "there is no just reason for Baltimore to have a portion of its confines labeled the tuberculosis section," and the Colored Law and Order League likewise pointed to astronomical tuberculosis rates in Lower Druid Hill as evidence alluding to the depravity that could be found there. Yet Lower Druid Hill's housing stock went unimproved, even with the housing code reforms that were passed in 1908 as the Druid Hill controversy was unfolding. In many respects, then, reform was more symbolic than substantive. The compiler of the newspaper clipping scrapbooks of the Maryland chapter of the American Lung Association (now housed at the University of Baltimore's Langsdale Library) inadvertently offered a telling juxtaposition in the winter of 1907-08. In December the Baltimore Sun reported on Janet Kemp's and Henry Barton Jacobs's illustrated lectures to the Baltimore Council of Jewish Women on the necessity of tenement reform, both of them urging the audience to political activism. On the same page of the scrapbook is another Sun article, from January 1908, announcing an MAPRT tuberculosis exhibit at the Colored YMCA, "not very far removed from Baltimore's 'lung block'." The point of the exhibit was not to arouse political sentiment, but instead to encourage black consumptives to take the "open-air treatment" in their homes and to take personal measures to prevent the disease. Apart from requiring several hours a day during which the patient may sit outdoors, the open-air treatment also assumes access to a ground-level or elevated porch, a rare sight in Lower Druid Hill.¹⁰⁵

¹⁰⁵ "'White Plague' Their Theme. Dr. Henry Barton Jacobs and Miss Kemp Talk to Women," Baltimore Sun 11 December 1907; "Tuberculosis Exhibit. Number of New Pictures on View at Colored Y.M.C.A.," Baltimore Sun 18 January 1908. Scrapbooks of the American Lung Association (Maryland chapter), Langsdale Library Special Collections, Series I Box 1.

CONCLUSION

“Tuberculosis is essentially a house disease,” Dr. J. Hall Pleasants noted in 1913, looking back on roughly a decade and a half of neighborhood studies and the failure of housing reform, “and yet we herd our negroes in dilapidated shacks and filthy alleys, where the death rate cannot help but increase.”¹⁰⁶ Three years later, Assistant Commissioner of Health William Howard, Jr. reported that an unnamed “large insurance company” had provided him a list of blocks and parts of blocks to which the company, citing a history of bad risk, would not issue policies. He was little surprised to find that spot maps showing pulmonary tuberculosis deaths in the city showed heavy mortality in exactly those areas, including the Biddle Alley district, that had been singled out for exclusion.¹⁰⁷ Drs. Pleasants’s and Howard’s collective lament marked a realization among health officials, less common fifteen – or even ten – years before. The state of black tuberculosis owed itself at least partially to housing conditions produced by an unevenly-structured and -regulated market.

Pleasants and Howard were hardly alone in making the allusion. Attendees must have nodded their heads in collective agreement when, at a much-publicized 1919 meeting of Baltimore’s health wardens, the warden representing Ward 17 (in which Lower Druid Hill was located) reported frankly that “housing conditions are deplorable in [the] district bounded on the north by Preston, south by St. Mary’s street, east by Druid Hill avenue, and west by Pennsylvania avenue.” The area for nearly twenty years had been known as Baltimore’s “Lung

¹⁰⁶ “Housing Blamed for Tuberculosis. Dr. J. Hall Pleasants Says White Plague and Negro Problems are Same,” Baltimore Evening Sun 20 November 1913, (Tuberculosis Clippings Scrapbooks, Henry Barton Jacobs Collection, Alan Mason Chesney Medical Archive, Johns Hopkins University).

¹⁰⁷ Department of Public Safety Sub-Department of Health Annual Report of the Fiscal Year Ending December 31st, 1916 (1917), 44. RG19, BCA.

Block.”¹⁰⁸ Yet specific plans for reform of lower Druid Hill or any black slums were few. Indeed, even when CHD officials (not the least vocal of whom was Howard) conceded that poverty, an exploitative housing market, and underemployment contributed to elevated black tuberculosis mortality, they inartfully dodged the issue and quickly fell back on blacks' personal behavior and “racial susceptibility” as factors demanding serious consideration.¹⁰⁹ Even as the city annexed new territory for residential development in 1918, a call for simultaneous housing improvements in black neighborhoods was the road not taken. City leaders' attitude toward lower Druid Hill more closely approximated quarantine rather than health preservation, as illustrated by mayors Mahool's and Preston's vigorous support for residential segregation. In the wake of the failure of legislatively mandated housing segregation, housing reform turned to housing demolition. The destruction of the Lung Block in 1929 appeared a solution to the dual and related problems of tubercular infection and the spread of property value decline.

Lower Druid Hill had been known as blighted even before the term entered political vocabulary in the 1920s. Yet its demise seemed almost hasty. The city's divisive and often violent segregation battles were a distraction that virtually shut down a discussion of planned housing construction to replace those buildings that fell before the bulldozer. What came before 1929, the subject of the following chapters, explains much. The antituberculosis movement in

¹⁰⁸ “Health Warden's Suggestions”, Baltimore Municipal Journal 7:9 (9 May 1919), 3.

¹⁰⁹ “One of the most difficult aspects of the question is racial susceptibility, or lack of natural resistance among the negroes to certain diseases, which will only be overcome after a long period of time or by the development of new means of preventive inoculation. It seems clear that one of the most important factors concerned in the disease problem of the negro is the adoption of all feasible methods of raising individual resistance. Granted fair housing conditions and an income adequate to provide proper food and raiment, there still remains the important question of education in the fundamental principles of health. Of these, diet is one of the most important. This involves, of course, instruction in purchasing, selecting and preparing a balanced ration. In addition, some methods must be developed for widespread instruction in the principles of personal hygiene.” Report of Assistant Commissioner W.T. Howard, Department of Public Safety, Sub-Department of Health Annual Report of the Fiscal Year Ending December 31st, 1916, 1917, 48. RG19, BCA.

Baltimore began with the recognition of the Lung Block, but unfolded with exuberant optimism (many talked of the imminent eradication of tuberculosis) that proved unbecoming a problem as intractable as tuberculosis. When, by 1910, it was apparent that the enthusiasm of 1904 had been somewhat misguided, health officials spotlighted blacks, particularly black women domestic servants, as an unsurveilled reservoir of tuberculosis posed to infect the city's whites. More than housing reform, the institutionalization and quarantine of black consumptives emerged as the focus of the antituberculosis campaign. This, too, failed for reasons I describe in the following two chapters, and the shortcomings of tuberculosis control were amplified in the white public's mind by the threatened expansion of the black middle class into white-occupied areas to the east of the Northwest corridor in which they had been contained for thirty years. When Lower Druid Hill, Baltimore's Lung Block, fell as one of the first targets of the city's program of urban renewal, both blacks and whites of the middle class would applaud. Blacks had hoped that it would signal the removal of a district of intense vice and disease from their midst, to be replaced by a clean and policed school, park, and public housing edifice. Whites who had waged a failed twenty-year legal battle to keep residential segregation ordinances in effect looked to the Lung Block's demolition as a measure to maintain the property values of their lands to the east. In the end the black working poor of Lower Druid Hill could only watch and wonder what new home and landlord would replace the old.