White Plague, White City: Landscape and the Racialization of Tuberculosis in Washington, D.C. from 1846 to 1960

Ivie Orobaton

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White Plague, White City: Landscape and the Racialization of Tuberculosis in Washington, D.C. from 1846 to 1960

A thesis submitted in partial fulfillment of the requirement for the degree of Bachelor of Arts in Department Anthropology from The College of William and Mary

by

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Accepted for __High Honors__
(Honors, High Honors, Highest Honors)

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The article “A Warning to Whites,” published in 1910 in the Washington Bee, notes that whites are “selling their souls” to maintain this segregated city and the continued deprivation of African Americans in the alleys made tuberculosis “rampant, day and night, every day in the year… a relentless monster of death.”¹

This thesis explores the relationship between health and racism in Washington, D.C. during the twentieth century, with a particular focus on pulmonary tuberculosis in the African American community.² Throughout the nineteenth century and well into the twentieth, tuberculosis was a leading cause of death in the United States, but African Americans experienced an even greater incidence of the disease than the white population. Contemporary commentators debated whether this was due to a difference in “racial fitness” or in environmental conditions connected to housing. This thesis explores the evolution of theoretical approaches regarding racial disparity in the rates of tuberculosis in the United States, with particular attention to Washington, D.C. These theories, as developed by both African American and white scholars, demonstrate the change in the sociological and medical perspectives around health and the environment. Their studies directly challenged the racist hypothesis of “racial fitness,” but their arguments had their own limitations, specifically in how they saw the role of the environment in relation to the tuberculosis issue, either framing African Americans as victims or enablers of their circumstance. In turn, we can better understand these limitations and what they missed by thinking about the link between tuberculosis, residential segregation in the city, and wider patterns of migration to the capital. By arguing for a rereading of the early twentieth-century tuberculosis literature in the context of the intertwined crises of both housing

² The choice to not hyphenate is done by the author. This choice reflects the most neutral spelling of African America.
and racism, this thesis attempts to better understand the links between racism, economic marginalization, and health.

This thesis began as a bio-anthropological investigation into tuberculosis, with specific focus on Pott’s Disease among African Americans in Washington, D.C. during the 20th century. The skeletal population I was going to use as a lens into this phenomenon is found in the Cobb Collection at Howard University, a database of 987 de-fleshed cadavers providing complete skeletal remains of African American individuals in Washington, D.C. from the late 19th century to the mid-20th century. The Cobb Collection provides evidence of disease and contextual data on general geographic, socioeconomic and temporal settings in the city. In the process of developing this research project, I realized that all remains identified with pulmonary tuberculosis were dated from 1932 to 1959, which raised an interesting question about Washington D.C.’s urban environment that caused this disease presentation, and more importantly about what was happening in the collection process. Acquiring a skeletal sample is based on self-selecting inequalities, and research samples were typically poor and African American as they often could not afford to pay the processing fee of the morgue or were unclaimed. It also raised questions of whether tuberculosis was experienced differently along racial lines. However, due to the time constraints of the Honors Thesis schedule, I would not have had enough time to catalogue and examine all the skeletal remains in my sample to identify evidence of Pott’s Disease. Also, because Pott’s disease only occurs in approximately 3% of all extrapulmonary presentations of tuberculosis, I would not have had a large enough sample to make any viable statistical determinations. Using this data from the Cobb Collection, I broadened my research question to reflect a more historical approach that examines the changing

way that theorists understood and rationalized tuberculosis and how these rationalizations sometimes exacerbated the duration and severity of the illness by limiting black Washingtonians’ access to treatment.

This thesis draws on a range of primary and secondary sources, but the most immediate model is Samuel Roberts Jr.’s *Infectious Fear: Politics, Disease and the Healthcare Effects of Segregation*, a historical analysis of the discourse on the intersection of race and disease in early twentieth-century Baltimore. Roberts’ exploration of the social construction of health and the experience of illness within the African American community in Baltimore, Maryland during the tuberculosis outbreaks of the 20th century demonstrated that health and the experiences of illness are linked to broader social and political phenomena. This linkage between social rhetoric and healthcare demonstrated that treatment was predicated on a system of exclusion rooted in social issues of race.

While Roberts’ work is trailblazing, it also has limitations. In particular, his book is a historical and political study of African American health, especially how African American healthcare moved from a position of neglect to part of the mainstream healthcare system, and it does not specifically focus on tuberculosis. The second limitation is that his study of Baltimore, as a case study of a large African American population, is not focused on the particularities of the city and how they contributed to the presence and spread of tuberculosis. Roberts treats tuberculosis and the landscape of Baltimore as clues to the larger issue of medical racism; the focus of the book looks outward to large trends in American medical and social perceptions of disease rather than an introspective analysis of the city itself.

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To address these shortcomings, I draw on the work of biological anthropologist Clarence Gravlee’s article “How Race Becomes Biology: Embodiment of Social Inequity.” 6 This article expands beyond the limitations of Robert’s contribution as it addresses the significance of the relationship between the environment and disease. For Gravlee, race becomes biological because of racial inequality, which in turn shapes the lived environment.7 It is within these external conditions of socio-economic marginalization, poor housing, and inadequate healthcare that both a physical and social environment for disease to flourish is created.

This thesis addresses the same discourse linking race and disease outlined by Roberts, but within the context of Washington, D.C. I differ from his contribution by going beyond a focus on discourse and examine how the built environment of the city shaped the conditions that enabled the racialization of tuberculosis. I also assess how the rhetoric and the ideological debates around the causes of tuberculosis were entwined with the practical responses and realities of the city.

This thesis is divided into three chapters. The first, “The Landscape of Washington, D.C. and the Emergence of Tuberculosis in the City,” addresses the medical and social history of the disease. It also examines the relationship between urbanization and tuberculosis, with a specific focus on the implications of racial zoning within the city as a contributing factor in the rise of alley dwellings and the racial disparity in the tuberculosis rates in the city. The second chapter, “Practical Responses to Tuberculosis (1846-1910),” discusses the two main tuberculosis treatments available - sanatoriums and hospitals - and how differential access to treatment affected the ongoing tuberculosis crisis in the city. This chapter also addresses the response to this lack of health services and public health initiatives for the African American community and the rise of the self-help movement to fill this void. The third chapter, “Ideological Debates

Around the Practical Response to Tuberculosis (1890-1930),” discusses the changing medical and sociological perspectives on the disease and how these different ideological frameworks affected the practical responses to tuberculosis issues within the city. In the conclusion, I return to the broader themes of the differential access to healthcare within the city and the housing conditions within the African American community. I also address how the ideological frameworks developed to address the issue of tuberculosis shaped both the medical and social response to the disease within the city.
Chapter 1: The Landscape of Washington, D.C. and the Emergence of Tuberculosis in the City

This chapter discusses the association between urbanization and the rise of infectious diseases like tuberculosis. It shows how changes in the physical landscape of Washington, D.C. through segregation, racial zoning and the development of the city beautification movement created a housing crisis. This housing crisis and reorganization of the landscape created the housing conditions specific to the African American community that enabled the spread of tuberculosis.

Medical and Social History of Tuberculosis

Tuberculosis has a long history and an extensive *materia medica*. Like elsewhere, the illness as it appeared in the United States historically transgressed class, racial lines and geographic borders. The presence of tuberculosis in America dates back to the early colonial period, but it was not until the beginning of the 19th century that the incidence of the disease increased dramatically due to the rise of industrial cities.\(^8\) Tuberculosis in America was marked by two phases: the first, from 1800 to 1870, was an epidemic responsible for 1 in 5 deaths in the country.\(^9\) The second, after 1870, saw a decline in tuberculosis cases in the general population but a concentration of cases within immigrant and migrant slum communities. This change in disease pathology reflected broader societal and environmental changes.\(^10\) Already by the 1840s, tuberculosis was containable in hospitals and through at-home preventative measures, but it remained incurable. It was not until the mid-1940s, a full century later, that scientific

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developments changed the social understanding and experience of the disease and changed it from an inevitable death to a treatable illness.\textsuperscript{11}

Tuberculosis emerged with the advent of sedentarism, as it is spread through interpersonal contact.\textsuperscript{12} With the development of permanent settlements and communities, the spread of diseases became easier and deadlier because people were in closer contact with each other.\textsuperscript{13} Tuberculosis is caused by the bacterium \textit{Mycobacterium tuberculosis}, commonly known as \textit{tubercular bacillus}.\textsuperscript{14} The mechanism for its transmission is through liquid particles, such as those created by coughing, sneezing, laughing, and singing.\textsuperscript{15} The bacterium is released into the environment, where it is inhaled and subsequently spread.\textsuperscript{16} While this is the primary method of infection, it is also possible to acquire the bacteria from surfaces, as it can remain viable outside the body for up to two hours.\textsuperscript{17} This makes tuberculosis a highly infectious disease.

During the 19\textsuperscript{th} century, the United States underwent significant social and economic changes that affected the spread and incidence of tuberculosis. Industrialization led to a rise in urbanization, the development of urban industrial and manufacturing centers, and the expansion of transportation networks. These social changes, coupled with an increase in migration from southern states into northern industrial centers, saw an influx of people into cities often ill-equipped to handle the large numbers of new residents. Many of these migrants arrived from rural areas and were typically young or adolescent men, and later, women. The places they occupied in cities like New York, Philadelphia, Baltimore, and Washington, D.C. were often small, overcrowded buildings with several people living in a single room; the sanitation in these

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\textsuperscript{13} & Alexander Mercer, \textit{Infectious, Chronic Disease, and the Epidemiological Transition: A New Perspective} (New York: University of Rochester Press, 2014), 120. \\
\textsuperscript{14} & Ibid. \\
\textsuperscript{15} & Ibid. \\
\textsuperscript{16} & Ibid. \\
\textsuperscript{17} & Ibid. \\
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buildings was abysmal. Many of these buildings were erected near factories where the poor worked, so the air quality and general living environments were often affected by industrial contaminants.\(^1\) These workers lacked balanced nutrition and adequate caloric intake, making them more susceptible to disease and other physical ailments. It was in these conditions that tuberculosis was able to spread with mortal efficiency. The typical disease pathology was among young adults, even as it was omnipresent in all society well into the 20\(^{th}\) century.\(^2\) This is significant because, traditionally, it is the very old and the young most acutely affected by disease, as their immune systems are often compromised or underdeveloped, inhibiting their ability to fight infection. This indicates that if young adults, typically the healthiest segment of the population, were susceptible to this type of disease, the environment – including nutrition and living quarters – are likely causative agents in their poor health.

**The Landscape of Washington, D.C.**

Washington, D.C. offers a unique perspective on the tuberculosis crisis because the city itself is anomalous for a number of reasons. First, the city was different from other contemporary cities because it was planned while other larger city centers like New York or Baltimore formed organically around preexisting settlements. Washington, D.C. was created inorganically through a congressional order. Second, the city’s grid pattern was modeled on the golden ratio. These dimensions created an inconsistent block formation resulting in uneven settlement areas.\(^3\) Third, because the city was planned, the monumental and ceremonial spaces were the main focal points

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\(^2\) John F. Murray, “Mycobacterium Tuberculosis and the Cause of Consumption,” 1086.

rather than the settlement areas.21 Unlike other comparable cities, demographic distribution within the city was uneven. Small sections of the city, typically African American communities, were extremely dense, while other sections of the city were less densely populated. Fourth, the built environment of the city and the political power that rests there were essential to its narrative, but the physical location of the city, south of the Mason-Dixon Line, is foundational to its political and social dynamic.

The nation’s capital underwent many iterations from its creation in 1790, when open plantations and swampland gave way to Washington City, then the District of Columbia, and finally Washington, D.C. These three stages mark its transition into the “gilded city” of the modern era. From its conception, Washington, D.C. has always been an anomaly. By its very nature it runs counter to the founding principles of the nation, as its constituents lack political representation. Contrary to the spirit of the Declaration of Independence, rather than being an active participant in government, Washington, D.C. became a “political colony” affected by the whims of national politics.22 This lack of representation placed the city at the center of the ideological nexus of the Northern and Southern cultural divide. The nature of the city as a living monument projected an image of an apolitical and cosmopolitan society that often blurred its foundations as a Southern city. Washington, D.C.’s location just below the Mason-Dixon Line classified it as part of the “upper south.”23 The influence of southern culture and politics is rooted in two political decisions relating to the formation of the city: The Residence Act of 1790 and the acquisition of 10 square miles on which it was built.

21 Ibid.
23 Charles Mason, Jeremiah Dixon, James Smither, and Robert Kennedy. A plan of the west line or parallel of Latitude, which is the boundary between the provinces of Maryland and Pennsylvania: a plan of the boundary lines between the province of Maryland and the Three Lower Counties on the Delaware with part of the parallel of latitude which is the boundary between the provinces of Maryland and Pennsylvania. Map. Philadelphia: Robert Kennedy, 1768.
The Residence Act of 1790 was “an Act for establishing the temporary and permanent seat of the government of the United States.” This act, by both the Senate and House of Representatives, designated that a

District or territory, not exceeding ten miles square, to be located as thereafter directed on the river Potomac, at some place between the mouths of the Eastern Branch [Anacostia River] and Connogochegue, be, and the same is hereby accepted for the permanent seat of the government of the United States.

The proposed plan for the capital was modeled on Pierre L’Enfant’s 1791 survey and map of the area. He imagined the new federal capital as the “citadel… for the growing republic.” In reality, this projected image of liberty and republican freedom was a facade that covered over realities of the slave south. The land allocated for Washington, D.C. was carved out of the surrounding states of Maryland and Virginia. The land ceded from Virginia follows the Potomac River and the land from Maryland follows the Eastern Branch River (Anacostia). The prevailing myth of Washington, D.C. is that it was built on a swamp. In reality, the topography of the land was varied, comprising “marsh/floodplain, farm and pasture and undeveloped forest.” The majority of the land acquired was rich pasture and farmland on which tobacco and corn were grown. A planned canal system was to be constructed on floodplains.

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25 Ibid.
28 Dickey, Empire of Mud, 26-27., Asch and Musgrove, Chocolate City, 16-17.
29 Dickey, Empire of Mud, 26-27.
African Americans in Washington, DC

Washington, D.C always had a significant African American population prior to the Civil War, both free and unfree. Many were serving in a variety of jobs from federal positions to small businesses, but the majority were menial laborers.\(^{30}\) While the city tolerated this community, anti-African American sentiment was strong and directly linked to the rise in African American migration into the city. There were three key moments of African American migration into the capital: following the founding of the city in 1790, in the aftermath of the Civil War, and in the 1920s. Before the Civil War, the main impetus for the migration was to seek refuge from slavery and the oppressive social atmosphere in southern states, and to seek better economic opportunities. According to census data of 1830, the African American population in Washington D.C was 9,109, of which 4,604 were free and 4,505 were enslaved, representing about thirty percent of the city’s total population.\(^{31}\) By the 1850s, the African American population was 13,746, which was around twenty-nine percent of the total population. Of this number, 10,059 were reported as free.\(^{32}\) The rise of free African Americans in the city represented an ideological threat to the continuation of the institution of slavery. African Americans in Washington, D.C., unlike many southern cities, experienced a higher degree of freedom but they were still subjected to restrictive racist policies like the “black codes,” which curtailed their movement through the city and limited settlement, housing, and economic opportunities. The first of Washington’s “black code” laws were passed in 1808, and they were periodically tightened and strengthened in the later decades. These racial regulations served to maintain the power dynamics of the slave-master relationship after emancipation.\(^{33}\) The anti-

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\(^{30}\) Asch and Musgrove, *Chocolate City*, 97.

\(^{31}\) Ibid, 98.

\(^{32}\) Ibid, 98.

\(^{33}\) Dickey, *Empire of Mud*, 91.
African American sentiment was based in the belief that African Americans were “nuisances” and that their presence corrupted southern values.\(^{34}\) By the advent of the Civil War, the African American population measured 14,316, approximately sixteen percent of the total population, with 11,131 classified as free.\(^{35}\)

In the immediate aftermath of the Civil War, the city was teeming with newcomers, especially free blacks, migrant laborers, and foreigners, attracted to Washington by the mythos of the city as a place of liberty and republican freedom. They thought of Washington as a place that offered many economic opportunities and a sense of anonymity. Yet the move to Washington did not always materially improve their circumstances. Many of the newcomers were former slaves seeking freedom. Many of them settled in areas of Washington, D.C. such as Foggy Bottom and Murder Bay, notorious for their marshy land, which were also locations of contraband army camps. Other newcomers to the city were Irish and Scottish immigrants. While they benefited from their classification as “white,” these immigrants still experienced significant class and religious bigotry as they were considered “wild-looking, undisciplined and turbulent people.”\(^{36}\)

They, like the African Americans, were relegated to the undesirable locations. As this wave of new migrants filtered into the landscape, the housing situation rapidly deteriorated when housing supplies fell significantly short of demand.\(^{37}\)

Compared to other parts of the South, the move to Washington gave migrants a higher degree of movement through the city and potential for social mobility within the context of the southern social order.\(^{38}\) Yet former slaves, in particular, found severely limited employment

\(^{34}\) Asch and Musgrove, *Chocolate City*, 98.
\(^{35}\) Ibid.
\(^{36}\) Ibid, 102.
\(^{38}\) Asch and Musgrove, *Chocolate City*, 44, 58-59.
opportunities. On the surface, the city seemed like a beacon of hope. In reality, employment opportunities for freed men were extremely limited both inside the city limits and in the countryside.\textsuperscript{39} If African Americans were able to find employment, there was a gender divide within the labor force, with women engaging in domestic labor like housekeeping, childcare, sewing, or laundry work, while the men engaged in more manual labor like construction and bricklaying.\textsuperscript{40} Many of the migrants into the city were typically employed in manual labor jobs and upon arriving in the city sought training in institutions run by the Freedmen’s bureau to improve their chances for employment.\textsuperscript{41}

By the 1880s, Washington, D.C. had become a cultural beacon of progress and improvement, at least for its most affluent citizens. This shift in the city’s image was accompanied by the replacement of the “old-line” Southern families with a new class of nouveaux riches, political agents, and business magnates, reflecting the growing power of the federal government.\textsuperscript{42} With this increase in power, the city’s population doubled from 131,700 in 1870 to almost 280,000 in 1900, making Washington, D.C. the third largest city in the south, after Baltimore and New Orleans.\textsuperscript{43} Just as the city had been a magnet for poor migrants from rural areas and less affluent cities, it started to draw a burgeoning upper class.

As the social landscape of the city changed, so did the physical landscape. Emblematic of the new social developments promoting progress and modernization was the McMillan Plan commissioned in 1901. As the city entered the Progressive Era, there was a new focus on the “city beautiful” movement, which harkened back to the imagery and grandeur espoused by city

\textsuperscript{39} Kate Masur, \textit{An Example for All the Land: Emancipation and the Struggle Over Equality in Washington, D.C.} (North Carolina: The University of North Carolina, 2010), 69.
\textsuperscript{40} Ibid, 61.
\textsuperscript{41} Masur, \textit{An Example for All the Land}, 61.
\textsuperscript{42} Asch and Musgrove, \textit{Chocolate City}, 188-189.
\textsuperscript{43} Asch and Musgrove, \textit{Chocolate City}, 188.
planners like Pierre L’Enfant. These reformers and city planners believed that through the beautification of the city landscape, the behavior of residents would also improve. Central to this beautification process was the establishment of parks and other communal areas to promote “civic virtue,” as well as the monumentalization of key governmental buildings to invoke both awe and municipal pride.

At the turn of the twentieth century, Washington, D.C. also shifted from a walking city to one of automation. Before the Civil War, residents of Washington, D.C. accessed all aspects of daily life on foot as most lived in the downtown core or Georgetown. With the introduction of electric streetcars in the 1880s, land opened for development, resulting in the “rime of Washington [being] knocked off.” The integration of electric streetcars helped establish new neighborhoods beyond the limits designed by Pierre L’Enfant. The city became more segregated as neighborhoods became more economically and racially homogenous. The pattern of settlement in the city resulted in white people living in the city-center and African Americans living in the outer rim; as white settlement encroached on African American neighborhoods, only elite African American families were able to retain their homes. The persistent presence of well-to-do African Americans in some areas created a pattern of African American enclaves within “white areas.” Meanwhile, poor and middle-class African Americans occupied the outer communities like Tenleytown (NW), LeDroit Park (NW), and the West End in the outer rim of the city, but as racial and economic segregation increased it often pushed out older mixed neighborhoods in favor of a more homogenous demographic makeup.

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44 Asch and Musgrove, *Chocolate City*, 197.
46 Asch and Musgrove, *Chocolate City*, 189.
47 Ibid.
49 Asch and Musgrove, *Chocolate City*, 192.
The Emergence of Alley Dwellings

By the early twentieth century, city expansion and reorganization emphasized the association between African Americans and poverty. The majority of African American migrants were from the countryside in the deep South and occupied a unique space within the city landscape as both separate, due to their race, but also marginal because of their class within Washington, D.C.’s African American community. The emergence of alley dwellings as housing disproportionately inhabited by African Africans threatened the core sensibilities and imagery created through the façade of the city landscape. But the predominance of African Americans in alleys also promoted the fallacy that African American communities were monolithic, when in fact they were just as diverse as the white communities in the city, with upper, middle, and lower classes. The locations of the alleys directly corresponded to the racial zoning of the city. Segregation dominated Washington, D.C.’s landscape, and as mentioned above, during the early 20th century, African Americans were expelled from mixed communities and relocated into confined areas that were more homogenous. Racial separation was predicated on the desire to prevent racial mixing and to avoid the “corrupting” nature of African Americans. The creation of separate neighborhoods allowed for the maintenance of this social order and “racial happiness.” This new segregated landscape forced African Americans to settle and develop land in less desirable locations on the outskirts of the city, which were often underdeveloped and of poor quality. Furthermore, to prevent African Americans from moving into white neighborhoods the city issued a zoning ordinance that prevented the additional construction of single-family homes to maintain the “white image,” forcing the construction of

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50 Borchert, Alley Life in Washington, xi.
alley dwellings to address African American and immigrant housing demand. Residential zones available for African American settlement were found throughout the city but there was a high concentration in the North East (NE), North West (NW) and South East (SE) quadrants. These were high-density communities and slowly developed into blighted landscapes as more people migrated into the city. The overall mortality of African Americans in the alleys was 372 per 100,000, while on the streets it was 293 per 100,000; this made the death rate in the alleys nearly double to that of street level dwellings. It is in these communities where tuberculosis became the leading cause of death. African American mortality from tuberculosis in the alleys was 621.3 per 100,000, while in the streets the death rate was 433.7 per 100,000. Alley dwellings were an inadequate, low-cost solution to the lack of affordable housing available to new African American migrants. Alleys were a product of the city’s grid design, laid out in block patterns, with houses outlining the perimeter of the square and facing onto the streets. To manage pedestrians, carriages, and later automobiles, these blocks had smaller roads, or alleys, that cut through them, creating a cul-de-sac inside the blocks of row houses. These blind alleys became the site for the alley dwellings. The row houses along the main street were two-story buildings with four or more units and were designed to accommodate single-family tenants. These houses offered a stable foundation for the alley dwellings when the alley lots were repurposed into “habitable” dwellings. The alleys, prior to the construction of the internal dwellings, were “open” plots behind the row houses with a small backyard, containing “a water hydrant, privy, and

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52 Ibid, 49.
54 Ibid, 45.
55 Ibid, 43.
While the row houses were constructed from brick, the alley dwellings were made of salvaged and cheap materials like scrap wood, tin, and other disposable building supplies. The average size of an alley home was twelve feet wide and twenty-four feet to thirty feet deep but the configuration of this varied per the location of the plot on which it was situated and the configuration of the neighboring residences. These plots were then subdivided into smaller lots to maximize the number of structures within the alleys.

The change to the landscape of the city expelled many African Americans who lived in enclaves throughout the city and forced them to relocate into ever smaller sections. As existing communities were pushed into these new neighborhoods, new migrants into the city also settled in these spaces, leading to a massive imbalance in the city’s population density, with the African American sections being the densest while the white sections were less populated and more dispersed. The plots behind the row homes were subdivided even further to meet the demand for additional houses. This additional population pressure resulted in alley dwellings being built closer together and the size of the homes decreasing to allow for more homes to be constructed in the same alley corridor. This formation of a city block within a city block physically separated this community from the rest of the city. As a result of this built environment, the culture and community that developed within it were extremely insular.

The choice to use cheap and salvaged material reflected the rapid construction of the facilities but also the lack of care by the landlords and property owners for the tenants because they knew the options for housing were limited. The lack of permanent material made these dwellings susceptible to damage and a threat to the health of the inhabitants. The physical

58 Ibid, 28.
59 Ibid.
60 Ibid, 29.
61 Ibid, 28.
orientation of the blind alleys created an environment where the circulation of fresh air was limited, becoming worse as more people settled in these spaces. The increase of migrants settling into this limited space exacerbated the poor environmental conditions. It was in these areas of the city where tuberculosis was prevalent and disproportionally infected African Americans. Due to the highly contagious nature of tuberculosis, it spread easily with no preventive measures to minimize its impact. The development of alley culture was the result of a racial quarantine enforced through segregation to maintain the continued social stratification between white Washingtonians and African Americans. This social and physical marginalization created a culture of white reluctance to address the underlying issues, such as the environmental conditions like poor ventilation and deteriorated living conditions that contributed to the tuberculosis crisis. It was this steadfast reluctance to breach the “racial divide” that contributed to the persistence of deplorable living conditions which exacerbated the spread of tuberculosis.

Understanding the racialized landscape of Washington, D.C. will require further detail, and the question of tuberculosis brings up important questions about how various people responded to its presence. But the story of tuberculosis in Washington, D.C., including its racialized aspects, cannot be told without understanding the conditions that led to the presence of large, crowded African American neighborhoods in which tuberculosis could flourish. As shown in the preceding pages, this housing situation was the result of racial zoning practices that prevented African Americans from settling in a majority of sectors of the city; this forced existing communities to relocate into a smaller section of the city. This internal relocation created a phenomenon of over-crowding and a lack of adequate housing. The lack of access to housing forced new migrants to develop alley dwellings within the limited spaces available to

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62 Asch and Musgrove, *Chocolate City*, 203.
them. As migration into the city increased, the new migrants were pushed into these spaces, which increased the over-crowding and poor living conditions as the preexisting alley dwellings were subdivided, forcing a larger number of people into close quarters. This landscape of alley dwellings and slums created the conditions that allowed tuberculosis to spread with impunity and take root in the community, and many aspects of this racialized urban landscape persisted well beyond the passing of the tuberculosis epidemic in the middle of the twentieth century.
Chapter 2: Practical Responses to the Tuberculosis Issue (1846-1910)

The preceding chapter provided an overview of the link between African American experience of tuberculosis in Washington, D.C. and some of the racialized aspects of the urban landscape. While this is important for understanding how African Americans experienced tuberculosis, it is also important to look at the ways in which various people responded to the tuberculosis epidemic in Washington, D.C. The next two chapters discuss the practical and intellectual responses to the tuberculosis issue. The current chapter focuses on the years 1846 to 1910 when the first hospital was built in the city and government-mandated care was established. By 1910, African American community leaders established their response to the lack of targeted healthcare for African Americans. It examines how access to healthcare was predicated along racial lines, and how the continued persistence of tuberculosis in the city was a result of this racial discrimination.

The Sanatorium Movement

As a foil to the perceived destructiveness of the urban environment, the sanatorium movement embraced the healing power of nature as a new strategy for managing tuberculosis in Europe during the mid-19th century. The term sanatorium is derived from the Latin root sanare, meaning “to heal.” The sanatorium movement in the United States sought to use community and place for the purpose of healing, and in 1875, the first US-based sanatoriums were established. The most famous treatment centers were founded by Edward Trudeau in the Adirondack Mountains in New York State. He believed country life, fresh air, and daily activity were the best remedies for the persistent effects of pulmonary tuberculosis.64 The use of the landscape as treatment was a practical necessity, isolating patients to prevent the spread of contagion, but it

was also a way to escape from the noxious, dirty, disease-ridden city centers. These therapeutic centers, located in remote wilderness regions with large tracts of land for gardens, outdoor activities, and health centers, were refuges from the cities. It was the healing power of nature, and not simply the care of the doctors, that was believed to be the curative agent.  

The idea of natural healing powers was prevalent during the pre-antibiotic era. In Europe and America during the 19th century, divine intervention was often seen as the cause of disease and illness - it was God’s punishment for the moral corruption and failures of the individual or society. The cramped, chaotic city environment, rampant with disease, was the visual representation of moral decay, and sanatoriums were the direct response to this. Physicians and homeopaths in America in the mid-1800s understood the interaction with the natural world to be a significant regenerative agent. This medical ideology saw the environment, specifically the corruptive element of the cityscape, as part of the experience of disease and held that a change in environmental conditions could change the outcome of the illness.

The built environment of the sanatoriums embraced the natural landscape by building facilities as part of the landscape, rather than on top of it. Physicians believed that the fresh quality of the air could clear the lungs of the pollutants from the city and of the infection itself. Exposure to this clean air had the added benefit of increasing the oxygen intake of the lungs. This helped to reduce some of the respiratory symptoms of pulmonary tuberculosis like coughing, production of phlegm, and other breathing difficulties. As part of the prescription for clean air, patients spent the majority of their days outside on porches, often sleeping outside to maximize their air intake. The other key component of the treatment regimen was exercise to keep their

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65 Jill Nolt, “The Sanatorium Landscape,” N/A.
66 Ibid.
bodies strong, promote digestion, and alleviate melancholy and fatigue, common side effects. While these treatments provided some respite from the illness, they had no curative effect. Nevertheless, they remained the only treatment for tuberculosis until 1944, when the antibiotic streptomycin was developed.⁶⁸

While these healing facilities were situated in isolated spaces, they were strategically positioned along railways or well-traveled highways. This limited the strain of travel for consumptive patients but also maintained the perception of still being a part of modern society. This façade alleviated patient concerns about their separation from family, which was usually for long periods of time. The sanatoriums were self-sufficient units caring for all basic needs of the patients, and as such, they needed easy access to supplies for both the facility and staff. Self-sufficiency was rooted in their mission of isolation to prevent the spread of the contagion, but it also ensured that a vibrant community developed within the wards.⁶⁹ Isolation from the limited spaces of the cities allowed for the construction of larger facilities that could service all the needs of the patients – both physical and emotional.

The sanatoriums were not curative, but they were part of the early components of public health initiatives. These facilities were some of the first purpose-built isolation facilities to treat tuberculosis. The separation of the patient from the contagion and a toxic environment was seen as an essential component in treating the individual but also of treating the society by proxy. To address the growing number of terminal consumptive patients, the number of sanatoriums expanded rapidly. By 1904, there were 15 facilities in the United States. By 1923, there were 656 institutions with 66,000 beds, still insufficient to meet the demand. By 1953, as the movement was being phased out in favor of more specific treatments, there were around 893

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⁶⁹ Jill Nolt, “The Sanatorium Landscape,” N/A.
institutions; most were privately run and seen as refuges from public hospitals in the cities that primarily treated the poor. While these facilities met part of the medical needs of the affected communities, there were strict quotas and threshold indicators that limited access to them. Any patients who displayed terminal indicators were not treated; only those in the primary, secondary, or latent stages of the illness were admitted. Wealthy white patrons who could afford the travel, room and board, and medical costs made up most of the patient population. While some sanatoriums were created for the working class, or people with “short purses,” sanatoriums were predominantly for the wealthy, and hospitals were for the poor.

The sanatorium represented a place for treatment, while hospitals were places for people – specifically the poor – to die. Poverty and race were limiting factors in access to care and carried the social stigma of disease and moral corruption. Hospitals, specifically tubercular wards, expanded the breadth of treatment and access to care for the indigent, African Americans, and terminal consumptives. Even though care was extended to these populations, the social policy of segregation and racial animosity influenced how care was allocated. As a general rule, African Americans were not admitted onto the same wards as whites, but most facilities could not meet the African American demand for beds. To address this need, many states created separate facilities for working-class whites and African Americans, usually in cities with large African American populations like Baltimore and Washington, D.C. Another option for treatment was out-patient care from public hospitals, which reduced the cost of housing patients. The limitation of this method was that there was no national standard for community health centers

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72 Ibid, 462.
74 Roberts, Infectious Fear, 176.
and clinical volunteers at the time, and in the African American and immigrant communities, there were few, if any, clinics for local out-patient treatment.

This difference between the treatment regimens of sanatoriums and hospitals placed poor African Americans at a significant disadvantage. The sanatorium movement was the only treatment for tuberculosis until the discovery of streptomycin. As the sole viable medical treatment, exclusion from it was a death sentence. Racial discrimination excluded African Americans from the premiere medical treatments offered by the private sanatoriums, forcing them to seek care in hospitals, which, before the advent of antibiotics, had no effective treatments. Their location in inner cities forced patients to recuperate in the conditions they were seeking to avoid. This inability to leave the unhealthy environment of the city contributed to the cyclical and heightened experience of tuberculosis for African Americans and poor immigrants. This differential in access to healthcare was most apparent in limited urban spaces like Washington, D.C., where the geographic parameters of the city and lack of space restricted the creation of large medical campuses. Compounding this was the lack of targeted medical care. Hospitals, unlike sanatoriums, were built to address multiple medical needs, and this often resulted in limited resources for tuberculosis treatments. The lack of targeted care created a medical and social phenomenon that forced infected people to remain longer in their communities before seeking treatment, facilitating the continued spread of the disease.

**Hospitals as Proto-Sanatoriums**

The earliest method used to address urban tuberculosis was to adapt sections of hospitals into tuberculosis wards. From 1846 until 1960, there were three main medical facilities in Washington, D.C. that provided treatment for tuberculosis for both whites and African
Americans: Glenn Dale Sanatorium, the Freedman’s Hospital (later Howard University Hospital), and D.C. General, also known as Gallinger Hospital. These facilities were public institutions funded by the government, making them legally obligated to treat indigent or non-paying patients. The number of beds available to African Americans at Glenn Dale Sanatorium and D.C. General were limited, as they had to be treated in wards separate from white patients. Freedman’s Hospital was the only institution founded as an African American facility that also provided care for indigent patients. These facilities were the only large medical institutions in the area that took active tubercular patients. Many patients attempted care at home before seeking treatment, either by choice or due to racial discrimination. Patients sought medical treatment only in the direst circumstances or when they were committed involuntarily because they presented a threat to their larger community. The establishment of tubercular wards within these public facilities illustrated the growing awareness that tuberculosis was more closely associated with poor urban populations than elites.

Freedman’s Hospital was founded by the Union Army in 1863, and was located in Camp Baker, the newly established contraband camp on the Custis-Lee estate in Washington, D.C. It was a facility created explicitly to care for the African American community as well as to treat illness and disease in the residents in the camps, the city, and neighboring states. Freedman’s Hospital was one of the oldest facilities to offer treatment for African Americans and to train doctors and nursing staff. The facility developed from a small hospital with three hundred beds to a sprawling campus comprised of a “general hospital with 351 beds and 51 bassinets and a

75 Leah Y. Latimer, “Quarantined: How a daughter was robbed of her mother’s affection through ignorance, carelessness and fear,” The Washington Post, December 10, 2006, 3.
76 Dickey, Empire of Mud, 184.
77 Ibid; Robert Reyrones to Honorable Colombrie Delano, September 23, 1874. Reel 1, Frame 93. Records of Freedmen’s Hospital, 1872-1910.
Tuberculosis Annex with 150 beds.” The campus also included homes for nurses, residences for interns and other employees, as well as a garbage facility, warehouse, and power plant. This institution sought to create a self-sufficient facility in an isolated location rather than having dispersed treatment centers. Located within city limits in the NW quadrant, both staff and patients could be close to all necessary resources while minimizing the spread of contagion. However, it still fostered a sense of alienation between patients and the community at large, which added to the ostracization of tubercular patients, who were already stigmatized by having the disease. Prolonged hospital stays, or recurring visits, further stigmatized them. One of the dominant narratives in tubercular accounts was the separation of families. This was often extremely traumatic for both the patient and the remaining family members as there was a persisting uncertainty about whether they would return home. A letter to the editor of the Washington Bee illustrates how devastating tuberculosis could be for families. The writer, working with an organization called Associated Charities, appealed for help for “an unfortunate colored family”:

The father, a young man who was always a steady, hard-working man, has broken down and is now in the Tuberculosis Hospital. This leaves a wife and six children practically penniless. Four of the children are delicate and probably have tuberculosis. The mother formerly did laundry work but can no longer do so as it is not safe for people to send their clothes to her house. The man’s former employer, and his church, are doing all they can to help but in addition to that, they will need $39.00 per month. Will you not publish these facts in your paper and call upon your readers to lend a hand?

The function of the Freedman’s Hospital as a “charitable” institution serving the poor and indigent patients meant that administrators were dependent on adequate government funding to

79 Dickey, Empire of Mud, 184.
80 Cobb, “A Short History on Freedmen’s Hospital,” 271.
81 Latimer, “Quarantined,” 2.
provide the necessary services. Often the allocated government money was not enough to cover the cost of running both the general hospital and the Tuberculosis Annex as well as the facility at large, meaning the hospital was run at a loss.\textsuperscript{83} This lack of consistent and adequate funding often impacted patient treatment. This is significant because the population directly affected were patients who sought treatment in the advanced stages of the disease.

Gallinger Municipal Hospital, renamed D.C. General Hospital in 1953, was established in 1806 near Judiciary Square and moved in 1846 to the edge of city along the banks of the Anacostia River.\textsuperscript{84} Like Freedman’s, Gallinger Hospital was a public facility, serving all of Washington, D.C., but the designation as “public” made it synonymous with the poor and underclass, making it “[a] place familiar to one half of Washington as it is alien to the other half.”\textsuperscript{85} The hospital followed a “campus model” similar to Freedman’s, with a general hospital that eventually grew to accommodate 45 buildings over 65 acres. This model physically and socially isolated patients from the rest of society because, once admitted, they were confined to the limits of the facility, effectively marking them as agents of illness.\textsuperscript{86} The hospital underwent a significant expansion in 1923, adding wards for “tuberculosis, child disability, psychiatry and venereal disease.”\textsuperscript{87} The tuberculosis ward housed 226 beds, with an additional 250 beds for contagious disease. These wards were not explicitly segregated by race as it would go against the motto of the hospital, which was to treat all in need, though patients were separated by gender.\textsuperscript{88} These additions to the hospital reflected the growing concern about the contagion of tuberculosis

\textsuperscript{83} First Assistant Secretary at the Department of the Interior to Surgeon on Chief at Freedmen’s Hospital, July 15, 105. Reel 5, Frame 1003. Record of Freedmen’s Hospital, 1872-1910.


\textsuperscript{86} Fenston, “From Public Hospital to Homeless Shelter: The Long History of D.C. General.”

\textsuperscript{87} Ibid.

\textsuperscript{88} Ibid.
in the city but also the renewed focus on public health. Gallinger Hospital was not solely a hospital but “part poorhouse, part asylum, part hospital, part medical school, and part jail.”89 The chronic lack of funding and minimal staff created an environment that was “wholly unsuitable for the purpose of the sick.”90 While the hospital grew and expanded to address the medical needs of the city, it never overcame its original purpose.91 In 1929, the hospital stopped accepting non-paying patients, but it was still perceived as a poorhouse hospital.92

Hospitals like Freedman’s and Gallinger, which were designated as public institutions, suffered from overcrowding and chronic understaffing. This forced staff to enact a constant triage for the sickest patients, invariably turning away patients who were affected to a lesser degree.93 The hospital policy to only accept the sickest patients placed both the community and the affected patients at risk because treatment is not effective in the later stages of the disease. By prolonging the patient presence in the community, the health officials increased the risk of exposing more people to the disease. This method treated patients, not the community. For the African American population in the city, it increased the risk of spreading the disease in the community. The level of care afforded in these facilities was historically inadequate and predicated on class tensions rather than racial lines. Historian Tim Krepp notes, “If you [were] of any means whatsoever… you would not come here [as it is] the worst place you could possibly come.”94

These facilities treated patients as dependents rather than people. Their semi-suburban location was a key part of their treatment methodology, which contained elements of the

90 Ibid.
92 Ibid.
93 Fenson, “From Public Hospital to Homeless Shelter: The Long History of D.C. General.”
94 Ibid.
sanatorium movement. While these hospitals were located within the limits of the city, they were on the outer rim, in the most “rural” parts where the environment was cleaner than the inner city. They were also located away from most residential locations, specifically white housing developments. These locations allowed the government to create large treatment campuses that contained the disease within a limited space and also used the environment as a curative agent. This system of care was eventually phased out as residential settlements moved into “rural” spaces, turning hospitals into warehouses for the ill rather than viable treatment centers. This contributed to a treatment plan of isolation rather than cure, which was reflected in the conditions and environments at these facilities. The location of the hospitals in Washington, D.C. further reflected a larger ideology that associated the poor with illness and disease. The irony of this is that the requirements for admission into the hospitals ran counter to this aim. To reduce overcrowding on the wards, these facilities only admitted the sickest patients, which meant that patients who were symptomatic remained in the community, spreading the disease. The lack of funding allocated to public hospitals limited the treatment effectiveness and also created a pattern where patients were reluctant to seek care in fear of refusal, extending the time they remained in the community.

African American Community Response to Tuberculosis and the Politics of Respectability

African American communities in the South were especially vulnerable as they were socially and economically marginalized due to Jim Crow segregation and racial discrimination. This marginalization, especially in the urban environments, resulted in poor living conditions, overcrowding, improper ventilation, and rampant disease. African Americans suffered doubly as

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these impoverished conditions enabled the spread of disease, killing them at twice the rate of non-blacks, and because of their race, they were also denied basic medical services. With limited access to public medical facilities like state-run hospitals, private institutions were established to care for the black community. Though these private institutions addressed some of the healthcare needs, they were often expensive and were seen as a last resort. This restricted access to medical treatment meant that many African Americans received no treatment at all.\textsuperscript{96}

Though there was not a consistent public health reform, there were efforts to address these issues through brochures and other informational pamphlets. These preventive measures were developed for use in the home and how to manage tubercular symptoms. These procedures were printed in a 1897 pamphlet sponsored by the Pennsylvania Society for the Prevention of Tuberculosis: airing of confined spaces, increasing exposure to sunlight, cleaning of all surfaces with corrosive cleaning agents like lye, and separating contaminated material from the rest of the home.\textsuperscript{97}

These conditions laid the groundwork for the development of the National Association of Colored Women (NACW) in 1896, which made public health the mantel for local women’s clubs. The NACW was a representative body that generated a cohesive platform to address the public health needs of African American communities.\textsuperscript{98} The governing body served as a model for smaller community groups and health clubs to create tailored programs and initiatives to address tuberculosis and other services to their communities. Organizations for African American health professionals also played a leading role in helping more doctors learn about


prevention and treatment of tuberculosis. African American doctors shared information about tuberculosis treatment through the National Medical Association. The “ravages of the dread disease among the colored people” was a major theme at the 1908 national meeting in Boston, where African Americans doctors from Washington, D.C. were “much in evidence.”99 “Methods for fighting tuberculosis” also took center stage at a 1911 meeting of the National Association of Colored Graduate Nurses.100 These grassroots efforts were essential in the formation of health protocols and the distribution of care within African American community.

These efforts emerged alongside (and in some ways against) efforts to address tuberculosis beyond the African American community. One of the earliest organizations developed to address the public health crisis of tuberculosis in America was the Anti-Tuberculosis Association (ATA). Founded in the early 1900s to prevent tuberculosis, it established clinics in both white and black communities. By 1914 there were regional branches throughout the United States. The ATA was a white community organization that provided care for black communities in a paternalistic way. There was also a lack of racial diversity in the clinic staff. The care provided was determined by white physicians and nurses and not tailored to the needs of African Americans. This galvanized African American women’s groups to develop their own networks for care which could be tailored to specific community needs.101

Likewise the efforts of the NACW need to be placed in the gendered landscape of community uplift in the United States in this period. The Progressive Era (1890-1920) brought an increase in female civic engagement. The community, not the nation, became the site for reform. The middle-class, specifically women, were central to this mission as they symbolized

100 “Dr. A.M. Curtis Speaks. Miss M.A. Allen’s Great Work,” Washington Bee, August 26, 1911, 1.
civic and moral virtuosity in the cultural landscape of America. Their messaging focused on their role as “municipal housekeepers,” evoking the imagery of the maternal body as the guardian of morality, safety, and wellness because “the responsibility for the health of the family is largely upon the women.”

Women’s organizations on the local level were instrumental in generating community engagement and social development programs for a range of issues. Women used their positions as community figureheads to lobby for government recognition and increase social awareness, and their activism became the foundation for many of the programs in public health reform and community development. Middle-class African American women saw it as their responsibility to “improve” the lives and conditions of poor African Americans, as it reflected positively on them and was beneficial to the poor and the community at large. They believed progress could be achieved through modeling “correct and proper” middle-class behavior like sexual restraint and prohibition.

These women’s groups, often in tandem with churches, developed fresh air stations in urban open areas, and health initiatives to raise awareness of the highly contagious nature of tuberculosis for school curricula and community centers. These women’s groups also sponsored “Health Week” and “Tuberculosis Sunday” at various churches, Sunday schools and gatherings of young people around Washington to preach the “the gospel of good health and right living.”

This classism was a key component of the Progressive Era, which acknowledged the association between poverty, illness and disease.

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Despite the anti-tuberculosis efforts of the NACW, the first agency specifically created to address the tuberculosis issue in the African American community was the African American Anti-Tuberculosis Association, founded in 1909. It was modeled along Booker T. Washington’s ideology of African American occupational development. In response to the ATA, the African American community created their own Anti-Tuberculosis movement, founded on the established networks and programs created by the women’s groups. While the self-help movement aimed to elevate African Americans, it was still couched in class tensions as the mission statement for the NACW, which was a dominant voice within the self-help movement, called for the “moral, economic and social advancement of Negroes.” Similarly, J.E. Moorland, secretary of the Colored Men’s Department of the Young Men’s Christian Associations (Y.M.C.A.), advised branches of the Y.M.C.A. throughout the country to discuss tuberculosis during youth meetings and gym classes, and to “get at least one minister to talk or preach on the subject,” making clear his belief that health and morality were connected. 105

The women and men who ran these agencies saw their actions in addressing the tuberculosis issue in the slums as not strictly for public health, but to alleviate all the conditions – social and medical – that limited African American progress. This goal to advance African American progress was rooted in the class tensions created by the monolithic depictions of African Americans within the social consciousness. The overall lack of treatment options and training available to African American health professionals limited the breadth of treatments available to African Americans. Nevertheless, though these initiatives were not wholly successful, they still served a necessary and central role in galvanizing African American community engagement to fight against tuberculosis, as well as generating wider social

awareness of the environmental nature of the disease.\textsuperscript{106} The movement called for training African American doctors and nurses in tuberculosis care so they could treat the African American population and eliminate the need for patients to go to white-run facilities.\textsuperscript{107} The movement was mainly run and organized by local volunteers, who arranged meetings and spaces for educational and social policies to be implemented. Training new medical professionals was an essential component of the movement. Segregation and racist policies meant that there were few qualified black tubercular doctors, so much of the training had to be conducted alongside white medical practitioners.\textsuperscript{108} While this project was not entirely successful, it illustrated the important observation that social and economic oppression of African Americans was a causative agent in the experience of health.

As shown in this chapter, there were no effective treatments for tuberculosis during this period, but sanatoriums offered the best method to contain and treat the symptoms of the disease. While hospitals were the main treatment centers for the poor, they offered basic and limited care due to their budgets. This limited service often resulted in patient warehousing rather than treatments, and as Washington, D.C.’s population grew, so did the strain on the healthcare services. This limited number of hospitals in the area is rooted in the desire to limit institutions that create dependents, and hospitals and healthcare providers “attract a community of dependents” in large numbers.\textsuperscript{109} This unwillingness to create spaces for care dates back to the Reconstruction Area and the concerns of freed people attracting diseases into white communities.\textsuperscript{110} In this theory, the lack of treatment facilities would limit the concentration of

\textsuperscript{106} Torchia, ”The Tuberculosis Movement and the Race Question,” 167.
\textsuperscript{107} Ibid, 160.
\textsuperscript{108} Ibid, 162.
\textsuperscript{110} Downs, \textit{Sick from Freedom}, 88.
disease peoples in the city. Racism and socio-economic marginalization were key factors in the lack of African American access to adequate care and the majority of the tubercular patients could not afford treatment in private sanatorium institutions, the recommended treatment at the time. It is this inability to both physically and financially access treatment that forced many of these patients into sub-standard care facilities. The lack of adequate healthcare galvanized the African American self-help movement to develop treatment options for the city’s residents. While their efforts were not wholly successful, this activism contributed to the democratization of access to healthcare.
Chapter 3: Ideological Debates Around the Practical Response to Tuberculosis (1890-1930)

This chapter discusses the three main ideological frameworks developed in response to the racial differential of tuberculosis rates at the beginning of the twentieth century in Washington, D.C. The first is the racial heredity theory, which emerged during the 1890s and was popularized by Dr. Frederick Hoffman. The second is the City Beautification movement, which emerged around 1900 and lasted until 1910 and was linked with the redevelopment of the city center and National Mall. The third is the theory that focused on the built environment and poverty, which emerged in the 1890s but became more prominent during the 1920s thanks to a variety of activist scholars. I assess how these ideological movements evolved and impacted medical and social perspectives regarding tuberculosis. This chapter also addresses how Washington, D.C., in the post-World War I period, developed new medical and legislative responses to the tuberculosis issue.

Racial Heredity Theory

Around the turn of the twentieth century, a pressing question within the medical community was the issue of differential rates of tuberculosis infection between white and black populations. As the disease pathology changed from a general epidemic to primarily existing within impoverished communities, race became a more significant factor in both the medical and social experience of the disease. The African American communities in both rural and urban settings suffered two to three times the incidences of disease as their white counterparts, but in high-density cities, African Americans experienced rates of tuberculosis four to five times those of whites.\(^{111}\) There were three main ideological constructs developed to explain this phenomenon.

The first was the idea of racial heredity of tuberculosis, the second focused on socio-economic and environmental conditions, and the third was the idea that inherent personal moral corruption created poor environments that increased susceptibility to disease.

The ideological framework that supported the rhetoric of African Americans’ inherent susceptibility to tuberculosis originated in early attempts to conceptualize the mechanism of disease transmission. From the 1830s through the mid-1850s, as Europe grappled with epidemic levels of the disease, physicians struggled to diagnose its cause. The preeminent theories were that tuberculosis was caused by either miasma – a poisonous vapor or a contagious powder suspended in the air – or an inherited malformation, poor nutrition, or posture.\textsuperscript{112} While physicians during this period acknowledged that the theory of environmental causes held some merit, they were considered confounding factors of the “hereditary” nature of the disease. These assumptions were pivotal in shaping both treatment and the social perceptions of tuberculosis.\textsuperscript{113} The concept of tuberculosis as a hereditary disease was developed by physicians who observed that consumptive children either had parents with tuberculosis or other family members with the same disease. They hypothesized that heredity, not contagion, was the key mechanism for transmission, a perception of predetermined fatalism.\textsuperscript{114} They also conceptualized the disease as “a general body disorder,” meaning all aspects of the individual were affected, not just specific organs like the lungs, making the experience of the disease a state of being rather than an illness.

In the United States, the dominant voice for this narrative was Dr. Frederick Hoffman, an insurance actuary primarily working with vital statistics. He specialized in risk assessment for


\textsuperscript{113} Ibid, 458.

\textsuperscript{114} Ibid, 549.
insurance companies, healthcare services, and other institutions. His book *Race Traits and Tendencies of the American Negro*, published in 1896, was foundational in developing the expanded understanding of the issue of inherited tuberculosis. Dr. Hoffman argued that “race and heredity [are] the determining factors in the upward or downward course of mankind,” and he specifically focused on the “measurable” aspects of the physiological differences between African Americans and whites in the United States. He disregarded the “conditions of life” as the cause for the difference in rates of tuberculosis, and, drawing from the language of social Darwinism, he noted that it is a “fact [the differences between the races] to be observed in all parts of the globe, in all times and among all peoples, namely the superiority of one race over another, and the Aryan race over all.” Hoffman was essentializing the complex issue of race and socioeconomic status into a gradient of superiority. He used the physiology of his sample of African American and white soldiers to explain the different experience of tuberculosis between whites and African Americans within larger communities and cities nationwide. Through his analysis he attempted to demonstrate how this “general body disorder” is an indication of an innate “racial inferiority.”

Hoffman expanded the fatalistic perspective of the disease beyond the nuclear family to a societal level. The heredity theory was focused on clinical assumptions that were applied to the treatment of all patients. Hoffman’s conclusions were based in medical knowledge but were used to further a set of ideological constructs around “the downward tendencies of the colored race.” According to Hoffman, African Americans’ inherent characteristics of “a lack of energy, both

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physical and mental,” predisposed them to tuberculosis.  

They have no “high power of will to work or thought” and are only motivated by “the sharp whip of necessity.” By focusing on these allegedly inherent characteristics, Hoffman viewed the acquisition of tuberculosis as an extension of a failure of character.

Hoffman interpreted the migration trend as a tendency of African Americans to follow their “like” community rather than being motivated by “external forces” like voter restrictions and “general discontent.” What is significant about Hoffman’s analysis of this population trend is that he does not place any significant qualifiers on the reasons for the mass migration; rather, he sees this as an insignificant detail within his larger analysis of the African American “condition.” Life in Northern cities was a drastic shift from the way of life in the South, where a high degree of transiency between counties and states was common, especially within black populations. This was in direct contrast to Northern cities, where populations migrated into the city and settled permanently. The implication of this new migration pattern was that the large population exodus from the South was settling in smaller, highly concentrated neighborhoods in the north, where inadequate housing had been a long-standing issue. This was especially perilous for African Americans as they were already relegated to substandard housing and limited spaces by virtue of their race. Hoffman surmises that this mass migration and settlement in cities would be “disastrous to the advancement of the colored race” as it would result in higher death rates and a corresponding imbalance in birth rates, which would spell the eventual extinction of the African American race.

119 Hoffman, Race Traits and Tendencies of the American Negro, 313.
120 Ibid, 328, 313.
121 Ibid, 24.
122 Ibid.
123 Ibid, 19.
Through his analysis of tuberculosis, Hoffman argued that the differing reactions to the disease demonstrated a clear racial divide. He saw this as an indication of a predetermined racial hierarchy based not in society but in biology. Whites were placed physiologically, socially and economically ahead of other races as they “possess all essential characteristics …for the struggle for higher power,” and any failure to obtain this benchmark is not attributed to the social or environmental marginalization, but the biological condition – or race – of the individual. While Hoffman’s analysis was based on a small sample size, it was intended to clarify larger societal circumstances. He evoked his data to legitimize the social practice of racial discrimination and espouse the necessity of a racial hierarchy for the function of life and to protect social order. As part of this racial hierarchy, he assumed that the systemic inequalities experienced by many marginalized groups were not a result of their status as “other” but were instead due to the innate qualities of specific races. This naturalization of inequality was used to justify limiting medical assistance to African Americans because their rates of disease were not due to external influences, and therefore, there was nothing to treat. As a result, African Americans were denied healthcare and treatment that would have prevented the spread of tuberculosis. It also perpetuated a sense of ambivalence about this marginalized community, which limited the care provided and further contributed to the cycle of marginalization.

People as the Problem: The City Beautiful Movement

A second ideological framework rationalized this disparity in the rates of tuberculosis as rooted in the fundamental moral failure of the African American community. The framework evolved out of the “city beautiful” movement embodied by the McMillan Plan of 1901 and exemplified in the banner “White City.” Proponents of the “city beautiful” movement saw the

125 Hoffman, Race Traits and Tendencies of the American Negro, 314.
“shimmering Neo-classical buildings” as the ideal imagery for the new Washington, D.C.\textsuperscript{126} While the banner of “White City” referred to the white marble of the government buildings, it also had a deeper connotation - a desire to expel the undesirable underclass, the majority of whom were African Americans, from the newly beautified city. The McMillan Plan sought to reinterpret the city as a “work of civic art” by transforming Washington, D.C. into a technological marvel with railroad tracks, turning the National Mall into a civic park, establishing public green areas, and developing interconnected bridges, walkways, and parks along the Anacostia, Rock Creek Park, and Potomac rivers.\textsuperscript{127} The plan also worked to socially and racially cleanse the city. These developments fundamentally changed the city’s visual landscape into a coherent image of a neo-classical space while changing the lived environment for the poor and underclass.

The “city beautiful” movement espoused the rhetoric of poverty beautification. Its proponents believed environmental blight to be an innate aspect of the deficiencies of African American communities.\textsuperscript{128} The emphasis on the visual landscape of the city diminished and disassociated the systemic inequalities African Americans experienced. The aesthetic appeal of the environment was reflective of the community’s moral composition.\textsuperscript{129} The impulse to only address the superficial inhibited the implementation of programs and aid that would have addressed the larger social issues that contributed to the slum conditions.

The changes proposed by the McMillan Plan brought attention to Washington, D.C.’s housing crisis and the existence of the alley dwellings and slums. Adhering to the original blueprint for the city, the neighborhoods around the National Mall and the Capitol were

\textsuperscript{126} Asch and Musgrove, \textit{Chocolate City}, 198.
\textsuperscript{127} Ibid.
\textsuperscript{129} Ibid, 114.
interspersed with shanty towns and slums. These settlements needed to be relocated to build new additions along the National Mall. These changes were made for the wealthy and tourists, at the expense of poor and marginalized populations.\textsuperscript{130} A writer for \textit{Washington Life} in 1904 noted that “the greatest drawback to the civic beauty of Washington is the negro population, whose poor dwellings are found on every land, and constitute the greatest menace to real estate values in the city.”\textsuperscript{131} “Real estate value” became code for segregationist policies in the city that were invoked to limit African American settlement in “white” or elite areas. This forced many new migrants into limited sections of the city, thereby generating homogenous and separate racial neighborhoods and also creating the perfect conditions for overcrowded slums. The presence of African Americans in the city and alley dwellings and shanty towns demonstrated that the ideology of city beautification was an ineffective tool for behavior modification as the efforts to reform them were unsuccessful. The unwillingness to recognized and address the underlying issues that enabled the creation of these blighted areas illustrates the fallacy in this ideology.

\textbf{Poverty and the Environment}

The heredity theory dominated social and medical fields as the cause of the differential experience of tuberculosis along racial lines from the late 19\textsuperscript{th} through the early 20\textsuperscript{th} century.\textsuperscript{132} By the late 1920s, this theoretical and ideological construct eroded as a new wave of sociological studies from both African American and white scholars challenged it. This new analytical framework attempted to explain the discrepancy in tuberculosis rates as a result of poor socioeconomic factors, which contributed to the living situations of those affected. The incorporation of a sociological interpretation focused on analysis of the human condition and

\textsuperscript{130} Asch and Musgrove, \textit{Chocolate City}, 200.
\textsuperscript{131} Ibid, 201.
larger lifestyle issues rather than identifying race as the sole causative agent. This shift to an environmental cause followed in the wake of significant developments in medicine, specifically preventive measures against tuberculosis, which resulted in a more empirical understanding of the mechanism for transmission and disease pathologies. Much like the heredity hypothesis, this environmental approach fundamentally changed perceptions of the effectiveness and necessity of treatment, but, more importantly, it identified the preventive measures needed to avoid the disease entirely.

This ideological framework was informed by the reform movement of the late 19th century that sought to reform institutions like housing, prisons, and education to create a more equal society. The mechanism for change in these communities happened outside of government bureaucracy. Community organizing efforts garnered public attention that forced government action and policy. These reformers saw the clearing of the overcrowded alleys as pressing issues, but their position was rooted more in self-interest to protect elite communities from the “filth, disease and epidemics” than to aid the alley-dwellers. Compounding this was the location of many African American housing developments. As a member of the National Tuberculosis Association stated:

  You find him (the negro) living near the railroad yards, the river bottom, the dump pile, the back of streets and alleys, the slums...he is the victim of overcrowded houses; he lives in tenements that are literally nothing but a hovel with an insufficient supply of light, fresh air and decent accommodation.

The most significant trend to emerge from this new school of thought was the notion that environment, not race, was the determining factor in the difference in tuberculosis rates between

133 Asch and Musgrove, Chocolate City, 203.
black and white populations. Dr. Eugene L. Opie, from the North Carolina Sanatorium in 1936 noted, “the negro is not particularly susceptible to this disease, for whites, under similar unwholesome environments, suffer equally.”\(^{135}\) Acknowledging this environmental perspective changed the medical and legislative action to address this medical and social crisis as it opened a necessary discussion and investigation into the causes of these environmental differences.\(^{136}\) This also fundamentally shifted the social and medical engagement around the issue of tuberculosis, as it was no longer seen as a trait linked to racial difference but a disease that had the potential to impact the lives of white Americans, too.\(^{137}\) The significant differential between the rate of tuberculosis in African American and white populations was “a matter of vital importance to the white race,” as the rates of death impacted whites and African Americans alike.\(^{138}\) This growing social awareness of the greater implication beyond mortality rates illustrated the total effect of disease on a population, especially in relation to social mobility, access to care, and economic prosperity. Both the medical and legislative agencies no longer considered tuberculosis a disease of the Negro, but a disease of poverty.\(^{139}\)

The first key moment in this cultural engagement was the media’s reporting of the housing and public health crisis. *How the Other Half Lives* was published in 1890 by Jacob Riis, a photojournalist, reporter and reformer in New York.\(^{140}\) He used photography to create an evocative experience for his readers, bringing them into the lives and environment of his subjects.\(^{141}\) He placed marginalized communities at the center of his reporting, humanizing them

\(^{135}\) Ibid, 588.
\(^{136}\) Ibid, 588.
\(^{137}\) Ibid, 589.
\(^{138}\) Ibid.
\(^{139}\) Ibid, 587.
\(^{140}\) Encyclopedia Britannica, sv. “Jacob Riis,” Last Modified April 8, 2019.
by illustrating the tragic human price of marginalization.\textsuperscript{142} To highlight the stark disparity between the poor and the rest of society, Riis often juxtaposed the grandeur of cities like New York and Washington, D.C. with tenement and alley homes to illustrate how the visual blight of these communities was a reflection of inequality and corruption, not a lack of morals of the inhabitant. For him, “[a]lleys were ‘a festering mass of corruption’ that ‘kill home life and kill the home spirit.’”\textsuperscript{143} Through his reporting, he haunted the upper class with the realities of poverty, evoking moralistic and religious ideology to propel change through legislative action.\textsuperscript{144} The central message he conveyed was that poverty was not natural and that the physical environment had serious impacts on the bodies of the inhabitants of these spaces.\textsuperscript{145} This perspective was a direct counter to the heredity theory perpetuated by Hoffman, who theorized the presence of tuberculosis in the African American community as an inherent characteristic; instead, this theory understood African Americans as victims of the effects of racism and socio-economic marginalization. This issue now had a clear remedy – increased access to medical treatment and economic opportunities.

Through muckraker reporting like Riis’, the government commissioned its own investigation into the housing and environmental issues of the alleys. Mary Clare de Gaffenreid’s report \textit{Typical Alley Houses in Washington, D.C.} was published in 1896 for the Labor Department. She was a labor investigator primarily focused on conditions of working-class life and the impact of economic stratification on these communities.\textsuperscript{146} This report was funded through community fundraising to survey life in fifty alley dwellings in Washington, D.C. to

\textsuperscript{142} Ibid, vii.
\textsuperscript{143} Asch and Musgrove, \textit{Chocolate City}, 203.
\textsuperscript{144} Riis, \textit{How the Other Half Lives}, viii.
\textsuperscript{145} Ibid, xi.
catalogue the built environment, not the people. The report focused primarily on the environment as hampering the success and social mobility of the inhabitants, as “[they] are beyond the pale of decency and morality.” Like Riis’ report, it conveyed a sense that this issue was not inherent to the community but was a product of their social circumstance. This perspective demonstrated that tuberculosis was not the issue but rather a symptom of a larger socio-economic disparity, and it was within these marginalized spaces that epidemics occur. The report identified social and economic discrimination as the reason why aid and medical assistance to African American communities had been limited.

This growing focus on the connection between the environment and disease became a central part of the African American activism and medical profession. Dr. W. Montague Cobb was a pioneering anthropologist and the first African American to receive a doctorate in Physical Anthropology in 1932; he also held a medical degree from Howard University. Because of his position as both “of the community” (having been raised in Washington, D.C.) and an academic, Dr. Cobb was deeply involved in social and political activism. He was the president of the NAACP (1976-1982) and a member of other organizations dedicated to improving the living and social conditions of African Americans in the city. His activism and academic work evoked the rhetoric of the Respectability Movement, which focused on the elevation of African Americans socially and economically to a more equitable place within American society. Dr. Cobb’s academic work focused primary on how “race” and racial differences were conceptualized and how these constructions influenced the types of environments African Americans inhabited. He focused particularly on how racism impacted the health of African Americans, specifically the environmental conditions that promoted health disparities and the

147 Asch and Musgrove, Chocolate City, 202.  
subsequent lack of access to treatment. In his article, “The Negro as a Biological Element in the American Population,” published in 1939, he argued that the American Negro is not a separate racial group but rather is an “admixture of African, Indian and European blood,” and is therefore not significantly different from other “racial groups.” Therefore, the morphological features like skin color and other supposed “racial markers” are irrelevant and superficial. He believed that the marked differences between African Americans and other racial groups in American was due to a lack of opportunity and poor environmental conditions. This lack of social and economic resources marginalized this population through segregation, forcing them to occupy spaces that are not favorable to the human condition, resulting in high mortality rates. He ended the article with a prescription to elevate African American from their position of social marginalization into the mainstream. The first of his three key points for advancement was health, specifically placing their health needs at the forefront of this struggle, mainly in the eradication of diseases like “tuberculosis, venereal disease and pneumonia.” The second was to observe the “conditions of life,” to increase awareness for their environment and improve living conditions to support health and reproduction. The third was the increased awareness of their “full constitutional rights under [the] governments” and the continued advocacy for equality and rejection of “segregation or any other policy which would interfere with [the] ultimate assimilation into the American conglomerate.” Through this environmental paradigm, the African American experience of disease was being reconceptualized as a result of a historic

151 Ibid, 341.
152 Ibid, 340.
153 Ibid, 347.
154 Ibid.
155 Ibid, 348.
pattern of racial marginalization, not as a separate race-specific issue. This more holistic perspective highlighted the compounding effect of racism, segregation, and differential access to care. This intellectual paradigm had a resurgence in the post-World War I period, informing redevelopment policy to address the environmental effects of tuberculosis.

The Redevelopment of the Blighted City

In the 1920s, activists, government officials, private philanthropic groups, and scholars began investigating the association between poverty and tuberculosis. These agencies attempted to define and quantify the different components of poverty, such as the local community, the concentration of homes and development of enclaves, the characteristics of the occupants of the homes and the community, the organization of the home, home ownership, and the types of homes in which the subjects lived. Through this methodology, these agencies established a comprehensive documentation of the lived environment of African Americans in Washington, D.C., as well as their financial makeup. Their findings illustrated that the presence of tuberculosis was an indicator for larger systemic issues within the city that contributed to a system of inequality that allowed for the persistence of illness and disease within marginalized groups. Their recommendations to address these issues emphasized the need to redevelop the landscape and create new public housing to tackle the moral decay within the alleys. These recommendations included razing and closing blighted areas and moving the populations into the suburbs. This “treatment” would solve issues like tuberculosis as the inhabitants would be removed from the fetid conditions they inhabited.

The Interracial Committee of the Washington Federation of Churches, in association with William Henry Jones, the former head of the Sociology Department at Howard University,

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issued the report *The Housing of Negroes in Washington, D.C.: A Study in Human Ecology* in 1929. This investigation was drafted to assess the housing standards of African Americans in the capital and to understand why the conditions in Washington, D.C. were lagging behind other large cities like New York. This study analyzed how the makeup and internal dynamic of the African American community affected not only the lived environment but also the psyche of the inhabitants.\(^{158}\) The areas of focus in the study were the general health of inhabitants of the alleys and tenement housing, crime, and standards of living as they contributed to the overall environment of the city.\(^{159}\) The study noted, “Bad conditions here [in Washington, D.C.] tend to create indifference elsewhere, while good conditions in Washington tend to encourage the improvement of conditions throughout the country.”\(^{160}\) Like the symbolism of the Capitol, the lived environment of African American citizens served as a benchmark for the treatment and living conditions of African Americans nationwide.\(^{161}\) This sociological approach placed value on the individual and the family to counter the long-standing notion of African Americans as objects and property.\(^{162}\) Rather than dealing with abstract theory, this approach emphasized the human experience to assess modern life and situated the data in a human context, emphasizing the complexities within the African American community organization, but also the extent of the poverty they experienced.

Americans across the United States.\textsuperscript{163} It assessed factors such as race and financial capital to determine the ways poverty affected the well-being of different communities. The report was the product of a federal investigation and reflected a larger nation-wide crisis of economic disparity and social marginalization that emerged from the racial discrimination of slavery. The report determined that the conditions that enabled diseases like tuberculosis to proliferate were an indication of significant and systemic socioeconomic disparities predicated not on race but on racism. This renewed interest in the housing conditions and lived environments of African Americans led to an increase in legislation to address the living conditions as well as the economic and social impact of poverty on disease. In their recommendations, both government reports advocated for a complete redevelopment of the housing situation in the city.

**Legislative Action to Address Tuberculosis in Washington, D.C.**

Unlike the “white city” movement, which had sought to “cleanse” the city of its “problem” populations, the legislative action taken in the interwar period to address the presence of tuberculosis in the city was based on the environmental theory of post-World War I. While legislators and activists made significant strides to reform politics, education, finance, and industry, there was minimal attention given to the plight of poor African Americans. There were several legislative and reform actions between 1914 and 1945 such as the Alley Dwellings Act of 1914 and later in 1934, 1937, and 1945, which were attempts to change the health of the city’s residents, especially African Americans, through the management of the environment.

Like the Board of Health, the ADA was given a broad range of powers to legislate against and criminalize habitation, building, and the presence of sub-standard structures without understanding the underlying issues that enabled their proliferation. The Alley Dwelling Act of

1934 was sponsored by the Alley Dwelling Authority (ADA), later the National Capital Housing Authority (NCHA). The ADA was created by Congress in 1934 with the express purpose “to provide the discontinuance of the use of dwellings of the buildings situated in alleys in the District of Columbia.” This congressional agency would be the main body for generating legislative action on this issue. The language of the bill reflected a new focus on housing rather than public health, and noted that the alley dwellings were “injurious to the public health, safety, moral health and welfare [of the residents of the city].” The Alley Dwelling Acts of 1937 and 1945 directly dealt with land redevelopment and public housing initiatives. This shift reflected the diminished initiative from the government to address the public health issues caused by the alleys and slums in favor of development projects. The use of land redevelopment to address public health concerns in the alleys, like tuberculosis, evoked the ideology of the “city beautiful” movement. By physically eliminating the spaces that contributed to rampant illness, a cyclical pattern of disease could be prevented. It differed from the ideology of the McMillan Plan as it did not see the people – African Americans – as the cause of disease and environmental decay; rather, it was the socio-economic circumstances they faced that contributed to visual blight and elevated rates of disease.

Glenn Dale, a Sanatorium “inside the city”

The Alley Dwelling Acts sought to reform the built landscape that contributed to the tuberculosis problem. Alongside this, the post-World War I period saw the development of parallel efforts to assist those already suffering from the disease. In response to the persisting

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164 Borchert, Alley Life in Washington, 52.
tuberculosis problem, city officials proposed building a sanatorium. Glenn Dale was built in 1930 some 15 miles from Washington, D.C. in the “rolling hills and grassy meadows” of rural Maryland.\textsuperscript{166} Glenn Dale was an isolated, self-sufficient facility like Freedman’s and Gallinger Hospitals, conveniently located near a major highway and railway line.\textsuperscript{167} Glenn Dale became operational in 1934 with the explicit purpose of treating tuberculosis, as Washington D.C was experiencing the cumulative effects of decades of tuberculosis. It accepted paying patients, but only admitted them when all poor and indigent patients were taken care of.\textsuperscript{168} While this was a progressive policy, it reflected the social makeup of the city. A large segment of the population was poor and African American, but the facility did not become fully integrated until 1949. The hospital initially had space for 150 beds, but as the need for beds increased, Congress authorized more funds, allowing for the expansion of a children’s ward and adult wards. Glenn Dale became the main recipient of tuberculosis patients in the city because other hospitals were operating at full capacity.\textsuperscript{169} The presence of this institution reflected a victory for activists and reformers as it filled the existing void in medical care for African Americans in the city.\textsuperscript{170}

Glenn Dale was unique because it was a hybrid between the hospital and sanatorium methods of treatment. It was organized into hospital wards reflecting these principles, incorporating quarantine and providing for fresh air and sunlight in each building through either a solarium or breezeway on each floor. This differed from the traditional sanatorium organization of cottage-like buildings that housed a small number of patients. Each building had a sunbathing roof for heliotherapy and the Children’s Ward had a playground to promote extended exposure to

\textsuperscript{166} Alicia Lozano, “Ghost Tales: Inside Glenn Dale Hospital,” WTOP, October 27, 2015.
\textsuperscript{168} Maurer, “Abandoned D.C.”; Mike Perry, “Glenn Dale Hospital: Tuberculosis Sanatorium, Asbestos Asylum,” last modified June 23, 2016.; Maurer, “Abandoned D.C.”
\textsuperscript{169} Latimer, “Quarantined,” 3.
\textsuperscript{170} Ibid.
sun and fresh air, as vitamin D helped to fight off the disease. With its fully landscaped garden, the facility resembled a country resort more than a hospital.\textsuperscript{171} This embrace of the environment marked it as a more holistic treatment facility, better than the hospitals in the city because it addressed both pressing health needs and the emotional side of the disease.

While this was a victory in the medical sense, the social experiences of tuberculosis still remained the same. Treatment continued to be extremely isolating, with both society and families casting patients off once they entered the facilities. Though this was the most advanced medical treatment available at the time, tuberculosis could still be a death sentence and admittance into these facilities could potentially be the last time patients were seen. Physical isolation and family separation added to the burden of the disease.\textsuperscript{172} The discovery of the antibacterial medicine Streptomycin in 1944 marked the beginning of the phase-out of the sanatorium.\textsuperscript{173} As access to care expanded, African Americans now had the choice of both hospitals and sanatoriums, and with modern medicine, the distinction between them could be muted.

As shown in this chapter, the ideological constructs developed to explain the tuberculosis issue influenced how the disease was perceived and the approaches to treatment. The racial heredity theory was the longest lasting ideological construct. It argued that the disease was innate to the community and that environmental conditions were inconsequential in the acquisition of the disease; therefore, treatment would not be effective. As a consequence of this perspective, government officials did not establish consistent and meaningful health services to address this issue within the African American community, which contributed to the spread of the disease.

\textsuperscript{171} Mauer, “Abandoned D.C.”
\textsuperscript{172} Lozano, “Ghost Tales.”
The beautification movement instilled an intense focus on the visual appeal of the landscape. This doctrine saw the lived environment as reflective of the moral and conduct of the citizenry, which marked African Americans as agents of disease. This perspective saw a shift away from public health initiatives to address tuberculosis for redevelopment programs. Finally, the poverty and environment theory emerged in embryonic form among activists and journalists in the 1890s and reemerged in the 1920s, at which time it became the accepted medical and legislative perspective to address the tuberculosis issue. This was part of the policy behind the Alley Dwelling Acts and was central to the decision to build the city’s first and only sanatorium – Glenn Dale. As medical treatment evolved and became more specialized, the ways in which tuberculosis was conceptualized changed as well. This parallel dynamic illustrates that medicine operated within the boundaries of the social nexus.
Conclusion: The Passing of the Debate and the End of Tuberculosis in the City (1930-1960)

During the 20th century, tuberculosis was endemic within the African American community in Washington, D.C. The racialized experience of the disease was rooted in two aspects of the city: (1) the unequal zoning and lack of housing and (2) the lack of access to adequate healthcare services. The physical layout of the city, with its monumentalized city center and racialized zoning, meant it was a deeply segregated and unbalanced city. The African American sectors of the city were overcrowded because of the lack of available housing, and this problem worsened as more migrants settled in these areas during the periods after the Civil War and World War I. The development of alley dwellings was in direct response to this lack of housing; these buildings were often ill-constructed, and as overcrowding increased, they became subdivided to accommodate the burgeoning population. These living conditions created an environment where tuberculosis was endemic. Vulnerability to tuberculosis was caused by generally poor health, but more significantly it resulted from socio-economic conditions created by racial marginalization. This resulted in a population that did not have the financial recourse to afford or access adequate treatment. The lack of available health services exacerbated the existing vulnerabilities of this population and enabled the spread and entrenchment of tuberculosis. These differences demonstrate the biological impact of race; while “race” as a category is constructed, the social experience of this label creates a system of “othering.” It is through this marginalization that inequalities are reproduced, and it is within these spaces that the race has biological consequences.174 What gives the notion of race and racial categories its power is the social aspect: this process of “othering” institutionalizes stratification in everyday life, which perpetuates this system of inequality.

The discovery of the streptomycin in 1944 marked the beginning of the end of tuberculosis in the United States. The need for large sanatorium complexes like Glenn Dale diminished as the treatment became more targeted. In 1960, Glenn Dale Sanatorium officially closed, marking the end of the sanatorium movement in the city. With the advent of antibiotics, the threat of tuberculosis was greatly diminished. It also marked a democratization of healthcare, as treatment could be dispensed in non-specialized facilities like hospitals, meaning that populations that had traditionally been excluded from exclusive facilities like sanatoriums were now eligible for the same type of care. As treatment became universal and accessible, this color line within the disease diminished until it was a non-factor in the ideological rhetoric.

While both the trajectory of the disease and the intellectual debates around it changed, the environmental conditions that enabled the perpetuation of the disease remained the same well after the eradication of tuberculosis. The continued existence of the alley dwelling and the slum conditions that contributed to the tuberculosis crisis reflected the persistence of structural inequality that deeply affected the African American community. Inequality was achieved through racial discrimination and segregation; for much of the time, in the process of maintaining this racial hierarchy, white Washingtonians and the government prioritized separation rather than address the underlying issues, particularly the environment, that contributed to the tuberculosis crisis.
This is a map based on Insurance Maps of Washington, D.C. by Sanborn Map Publishing Company. It charts the different types of building within the alleys.
PHOTOGRAPH 9.
One-Room Apartment. “Down in the slums . . . This was a combination bedroom–dining room–kitchen in one of the old houses demolished by the N.C.H.A. on the site of the Carrollsburg Dwellings. Note the oil lamps and the stove. The picture recalls the sentence from the devastating indictment of the Washington slums by the District’s Territorial Board of Health in 1877. . . . ‘So domiciled are families with all the dignity of tenants having rent to pay.’” National Capital Housing Authority Collection.

Carl Mydans and United States Resettlement Administration, *Untitled Photo; Possibly Related to: Alley Dwelling near Union Station, Showing Crowded Tiny Backyards*, 1935, Negative Nitrate; 35mm, N/A, Library of Congress, Washington, D.C.
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