Chapter 1

The Southern Negro Problem and the Origins of Sociomedical Racialism

Historians of the African-American experience and American race relations characterize the turn of the century as a sociopolitical and economic low point for the black citizenry. It is a time when there is a "triumph of white supremacy" in the post-Reconstruction South (according to the works of John Hope Franklin), a sociopolitical and legal "nadir" for blacks (Rayford Logan), "retrogressionist" cultural beliefs about blacks (Herbert Gutman) and an ascendency of "conservative" segregationism (Joel Williamson). But these are only the broad strokes, an outline of constraints on black American life through the Gilded Age. The finer features within this big picture reveal expanding, sometimes frantic, miniature developments within government, education, social welfare agencies and police institutions to govern the spiraling, turn-of-the-century African-American mass.*

As black, native white and new European immigrant Americans underwent the initial jolts of modern urbanization, the Progressive Era expert sector took shape. This rising network of medical, public health, and social welfare professionals came to recognize that a severe black–white health discrepancy existed. Contagious diseases

*To call attention to subtle shifts in scientific, popular, and regional terms for African-Americans or blacks, I have retained the exact spelling of the word Negro (which was sometimes spelled with a lowercase "n") as it appeared in the original source. Sterling Stuckey, a leading authority on American culture and race relations, emphasizes that at the end of the nineteenth century, African-Americans preferred to capitalize Negro, while regarding "the lowercase spelling as an insult to their people." See his chapter, "Identity and Ideology: The Names Controversy," in his seminal work, Slave Culture: Nationalist Theory and the Foundations of Black America (New York: Oxford University Press, 1987), 193–244.
such as diphtheria, typhus, tuberculosis (also called TB or consumption) and, to a lesser extent, syphilis, emerged as the most serious threats to public health in the United States. The technical dominion and professional authority of the Progressive Era municipal and social welfare sector rested on gaining the public’s trust that it could ameliorate such health problems and the social ills of industrialization and urban growth. With blacks increasingly populating urban America and their disease rates presumably high, by World War I many public health and social service experts in medicine, education, industry, and government believed that the future of America depended on proper understanding and resolution of the black health “threat.”

Throughout the Progressive Era, then, municipal and social work leaders aggressively investigated and collected data on the physique, health, psychological characteristics, and crime patterns of black Americans. In medicine, the black health problem compounded existing professional insecurity and scientific woes. Establishing more effective etiologies and therapeutic approaches to TB and syphilis in general was seriously frustrating early twentieth century clinical and public health investigators. Now the ubiquitous blacks seemed to be especially subject to the destructiveness of these diseases. Most white medical authorities believed that high black American mortality rates from TB and syphilis, were caused by racial characteristics that could be explained by traditional syphilology, pathology, and social Darwinism. In the meantime, from within the lay black community and black medical profession, a largely voluntary public health movement emerged to curtail the spread of TB and other contagious health threats.

1

From the turn of the century to the mid-1910s, vital statistics and epidemiological data on the health of blacks were sparse. But by the end of World War I a crescendo of statistics grew supporting the idea that blacks posed a major public health menace. Five types of piecemeal data provided a generally grim picture of the death rates and health problems of black Americans: census returns on mortality of limited geographic areas; data provided by the United States Army on rejected applicants and enlistees; census reports on insane, blind, and deaf populations (then considered “sick and defective” groups); vital statistics provided by certain municipalities, counties or states; and morbidity reports of large hospitals. Overall mortality for blacks
in 1900 stood at 29.6 deaths per 1,000 population compared to 17.3 for whites. According to the report of the annual Conference for the Study of the Negro Problems held at Atlanta University in 1906, the topic of which was the health status of blacks, this mortality data also showed the "greatest enemy of the black race is consumption." The TB death rate for blacks in 1900 was nearly triple that of whites (485 to 174 deaths per 100,000 respectively). The next four most frequent killers of blacks were pneumonia (356 compared to 185 for whites), diseases of the nervous system (308 to 214), typhoid fever (68 to 32), and malaria (63 to 7).

Of these five leading causes for black mortality, one, the vaguely defined "nervous disorders," is degenerative (or noninfectious) and typically the end-effects of heart problems like atherosclerosis or cerebrovascular disease (stroke). Three others, typhoid fever, malaria, and pneumonia are infectious. These latter three illnesses have distinct, dramatic symptoms that appear in a matter of days. They are strongly associated with immediate environmental conditions. Typhoid fever is linked to unsanitary food products (especially milk) or water supplies, while malaria is vector-borne (transmitted by insects). Influenza-pneumonia in its acute phase normally lasts from three to five days and frequently occurs as a local outbreak in a close-knit setting of people such as households, prisons, army training camps, or orphanages.

As the twentieth century opened, TB posed the most persistent danger to the nation's black communities. TB stood above the four other leading causes of deaths in its uniquely complex symptomology and the severe socioeconomic damage it rendered. The disease created social havoc because it tended to strike individuals in the most productive phase of their life. Robert Koch (1843–1910), a precursor of bacteriology and discoverer of the tubercle bacillus, wrote that "[i]f the number of victims which a disease claims is the measure of its significance, then all diseases, particularly the most dreaded infectious diseases, such as bubonic plague, Asiatic cholera, etc., must rank far behind tuberculosis." Koch estimated that about one-seventh of all humans died from TB, and, if "one considers only the productive middle-age groups, tuberculosis carries away one-third and often more of these." Following infection, the risk of developing clinical TB varies highly. Also, the interval between the period of initial infection and the emergence of definite symptoms and debilitation may span a few weeks to decades. Today TB still ranks near the top among the world's leading causes of disability and mortality.

Just as these early mortality reports brought into focus the seri-
ous threat TB posed to blacks, the results of physical examinations on rejected military applicants and army personnel signaled a warning that venereal disease among blacks was comparatively high. The ratio of blacks and whites rejected by the military from 1901 to 1904 for key disorders revealed that blacks had annual venereal disease rates roughly 50 to 250 percent higher than those of whites. Atlanta University researchers, however, were careful to point out that military morbidity data for enlistees revealed that in some cases whites evidenced higher venereal diseases rates than blacks.

Data of 1904 on roughly 60,000 white and black troops, for example, contained a significant number of soldiers who had served in foreign countries such as the Philippines, Cuba, or Puerto Rico. These military records disclosed that the prevalence of venereal disease was about 25 percent higher for whites (109) than blacks (87). According to the Atlanta University proceedings, this discrepancy not only indicated obvious miscegenation, but also exposed the hypocrisy of linking venereal disease to alleged race traits of Negroes such as biological susceptibility or moral promiscuity. "[I]n venereal disease the foreign service of white troops has led to their excess," the proceedings state, "a curious commentary on imperialism."  

Mortality statistics available for some major cities for the years 1884 to 1900 also suggested that during the opening decade of this century, black mortality was substantially higher than that of whites. Consumption death rates in 1900 for blacks in Boston, Washington, D.C., Baltimore, and New York were 742 (per 100,000), 514, 448, and 503, respectively. By contrast the overall TB mortality rate for whites (in registration areas) in 1900 was 174.  

Gradually during the 1900s and 1910s municipalities, counties, and states passed vital statistics laws which established units within their health boards or general administrations for the specific function of collecting birth, stillbirth, and death statistics on a regular basis. The quality and extent of such units varied greatly from locale to locale, as the personnel and methods for their collection, mortality classification for these statistics, and ultimate benefit of this data were still defined differently by each locale or state. Some jurisdictions collected data weekly, others monthly, all did so annually. As this data grew, public health authorities and medical societies became more aware of the black–white mortality differential and were usually the first to interpret this data for their political and lay communities.  

These local vital statistics also showed TB death rates for blacks to be extraordinarily high. Typical was the report for June
1911 by the Board of Health of New Orleans. It indicated that of the 258 deaths of blacks in the city that month, TB was the leading killer (45), followed by heart disease (34), diarrhea, dysentery and enteritis (28), and Bright's disease (kidney disorder, 25). As for New Orleans's whites, there had been 375 deaths, with heart disease the leading cause of death (55) followed by diarrhea (52), Bright's disease (40), and TB (35). In Birmingham, Alabama, mortality information gathered annually by its registrar of vital and mortuary statistics, combined with information from other sources (such as private anti-TB organizations), disclosed a shocking discrepancy in TB mortality along racial lines. From 1905 to 1915 the average TB death rate was 80 (per 100,000) for white residents of Birmingham compared to 390 for blacks.

When statewide vital statistic offices were created, they provided another stream of information pointing to an extremely high death toll for blacks from TB. Indeed, the need for organized data on black health for counties and states with large concentrations of blacks was a prime rationale for initiating offices to pursue what was then called the "science of vital statistics." Among the first states to set up a vital statistics office in the South was Virginia, which passed its law in 1912 and collected its first statewide vital statistics in 1913. Although Virginia had been admitted to the federal census registration area in 1913, state health authorities still believed that a substantial number of births and deaths were still being overlooked. They stated that their new vital statistics unit was especially significant because its annual report would be "the first published by any American State [sic] in which there is so large a negro element—so serious a factor in public health—as large as in Virginia."

Health officials of Virginia were not surprised to find that TB death rates among black residents exceeded greatly those of whites. The 1913 data for nine of Virginia's largest cities which included Richmond (populated by 84,401 whites and 48,784 blacks), Norfolk (53,374 and 29,825), and Portsmouth (23,708 and 12,788), indicated blacks were dying from TB at over three times the rate of whites. "At the outset, then," according to Virginia's vital statistics report for that year, "we find in the city negro the direst sufferer from tuberculosis [while the] white citizen of these urban communities suffers lightly by comparison."

The tone of fatalism that Virginia health authorities cast on the health plight of black Virginians was especially evident in a section of the 1913 report, "Deaths in the Commonwealth." It disclosed a
mortality rate for blacks substantially higher than its birth rate. Statewide the black birth-to-death rate differential was 5.7 per thousand annually (23.9 to 18.2), but for whites 14.8 (26.6 to 11.8). In the urban areas, the health authorities found, “the colored race is losing more rapidly than it is gaining.”25 The urban black death rate exceeded the birth rate, 26.8 to 19.9; while these rates for urban whites were essentially the reverse, a death rate of 14.8 to a birth rate of 21.9. Such figures, if assumed accurate, according to Virginia health authorities “presage the extinction of the negro in the cities of Virginia.”24

Although state and federal reports on vital statistics contained bits of information that indicated especially healthy aspects of black populations, the medical and public health establishment tended to overemphasize the high black death rates.25 John W. Trask, assistant surgeon general of the United States Public Health Service, called attention to this tendency in a paper delivered at the American Public Health Convention in Rochester, New York, during 1915. Discussing the interpretation of mortality rates of the black populations, Trask urged that public health researchers explore more specific reasons for the high black death rate and “whether the factors which produce the difference in the death-rates can be removed and the colored death-rate lowered until it approximates that of the white element of the population.”26

Trask further recommended that black mortality rates of southern states and large cities be compared to those of smaller populations, rural populations, and to death rates of European (white) foreign countries. Finally, he argued that economic or industrial differences of a particular region’s black and white populations evidencing wide mortality gaps be explored to measure the ill effects of these factors. His own preliminary survey of federal census mortality data demonstrated that rural white and black populations frequently had only small mortality differentials, that age-distribution affected mortality strongly, and that the black mortality rate (in 1912) essentially equaled those of “the white populations of Hungary, Roumania, Spain, and Austria.”27 In light of these findings, he advised against a bedrock faith in the conclusion that “there was in the colored race some peculiar characteristic which caused it to have a death-rate higher than that for a white population similarly located.”28

Trask’s voice, however, like those of the Atlanta University study group’s a few years earlier, represented only a minor opinion compared to the dominant medical thought which linked race to the high infectious disease rates of black Americans. Dr. J. S. Fulton, a
secretary of the Maryland Board of Health, rejected the intent of Trask’s paper, stating that it “would require a more critical study” of the mortality data. While the points Trask made to deemphasize the race factor were interesting and “advantageous to the negro to believe,” Fulton commented bluntly, “the assumption of defective racial adaptation is . . . not easily disposed of.”

The way in which the nation’s medical, public health, and charitable sectors conceptualized and responded institutionally to the high prevalence of TB and syphilis among black Americans, provided the rough foundation for approaches to black health problems of later decades. This early idea system or epidemic imperative, combining biological and sociological notions that blacks were biologically most susceptible to primary infectious diseases, reflects that mainstream American society through the World War I decade generally viewed black Americans more as a source of contagion than as fellow victims.

2

Not only were TB and syphilis among the leading killers of the day; they also posed etiological and epidemiological terrains that were virtually impregnable. TB is usually spread by inhalation of airborne droplets secreted by persons usually severely diseased and who have tubercle bacilli in their sputum. Causal pathogens for TB had been identified by the historic bacterial laboratory research of Koch and his generation. Yet neither this basic research nor the larger community of clinicians could unravel ways to cut the spread of these diseases by human carriers. Several decades of international research and prevention campaigns had to pass before TB and syphilis could be managed effectively. Moreover, it would take many decades for populations in America to build up natural immunities to TB and other infectious diseases.

In the meantime, as World War I approached, social Darwinism, eugenics, and Euronalism stormed across the Atlantic into the American intellectual terrain. The initial stream of vital statistics and military medical records on black mortality and morbidity blended into an explosion of medical, psychological, and demographic studies on the negative effects of darker races and black Americans on larger society. These academic studies and popular scientific diatribes centered on establishing a fundamental connection between phenotypical race traits and mental illness, criminality, and low intelligence, as well as black (and, to a limited extent, foreign-born and female) bio-
logical inferiority and susceptibility to infectious disease.\textsuperscript{35}

At the turn of the century, no demographic or sociological researcher enunciated the racialist idea that black Americans were an inferior, even "dying," race so authoritatively as the health statistician, Frederick L. Hoffman. His 1896 study \textit{Race Traits and Tendencies of the American Negro}, and the clinical work \textit{The Surgical Peculiarities of the Negro} by the eminent southern surgeon Rudolph Matas, became standard references for medical and sociological research through World War I postulating race distinctions as the basis for the black–white health discrepancy.\textsuperscript{34}

Hoffman, whom Herbert Gutman describes as an "influential racial Darwinist," brought together the central threads of the "dying race" concept.\textsuperscript{35} These diachronic racialist concepts postulated that (1) slavery had had a civilizing effect on black Africans: "All the facts brought together . . . prove that the colored population is gradually parting with the virtues . . . developed under the regime of slavery"; (2) blacks possessed a "race or constitutional trait" for psychological disintegration and an "immense amount of immorality" from which syphilis and tuberculosis "are the inevitable consequences"; and (3) even if these factors did not exist, evolution in the tropical climate and uncivilized conditions made the gradual "extinction of the [Negro] race" inevitable.\textsuperscript{36}

During the opening decades of the twentieth century, Hoffman exercised great influence in the area of population studies of cancer. To his credit, he was one of the first influential statisticians to discount the theory that cancer was primarily an hereditary or infectious disease.\textsuperscript{37} Instead, he stressed environmental and geographical factors (such as "a civilized mode of life") that encouraged contact with irritants causing the disease, as well as distance of populations from the equator. "Native races" living near the equator ate simpler foods and wore looser clothes. "The almost non-occurrence of breast cancer among the women of primitive races" was because "[p]ractically all the women of native races live simple lives, are undernourished rather than overnourished, and wear clothing consisting of a single [loose] garment."\textsuperscript{38}

But Hoffman also framed his environmental cancer theories within a racialist conception, urging that the white race was more prone to cancer than the Negro one. In 1913 he told members of the American Gynecological Society meeting in Washington, D.C., that "[t]he element of race in cancer mortality [is] a matter of exceptional interest and importance."\textsuperscript{39} His argument throughout the 1910s and 1920s was that blacks had been generally free of cancer under slav-
ery, yet as their social conditions approached those of civilized whites so would the frequency of cancer among this race.  

Hoffman also stressed that racial “constitution” or anatomy, even if vaguely defined, was another factor affecting the incidence of cancer. In 1921 he examined clinical reports from the famed New Orleans Charity Hospital—an institution that traditionally admitted and treated patients regardless of color—for the decade 1909–19. These records showed that black women treated at Charity evidenced roughly the same number of uterine tumors as this hospital’s white women patients. What did he mean by Negro? he asked his audience, the Columbia (S.C.) Medical Society, and how did race affect cancer incidence? Hoffman explained that mulattoes had most likely a higher rate of cancer than “pure” blacks: “The term ‘negro’ for the present purpose is, of course, used in the generally accepted sense of the term, but if it were possible to separate the mixed-blood from those who are still relative pure-blood, I am inclined to think that the evidence would disclose a higher rate of cancer occurrence among those having a relatively large proportion of white intermixture.”

An important compendium of the presumably scientific, sociobiological, and medical literature supporting racialism was Robert W. Shufeldt’s America’s Greatest Problem: The Negro (1915). A major in the United States army medical corps, Shufeldt’s study contained extensive excerpts of anatomical and anthropological research he believed proved Negro inferiority. This research ranged from crude anthrometrics, “visual” evidence such as plates of photographs of black persons juxtaposed alongside those of apes, and evolutionist pronouncements, to clinical “reports” strewn with wild Negrophobic deductions. For example, Henry P. de Forest, a medical professor from New York quoted heavily by Shufeldt, asserted that “hospital records show that practically all male city Negroes indulge in promiscuous [behavior] and carry with them venereal disease.”

Shufeldt argued that civil equality and economic programs for blacks were only minor problems compared to the health peril created by the millions of freed Africans now concentrated in the United States and other Western countries: “The gravest problem to be faced in dealing with the . . . negro is not his or her industrial future or right to social equality with the white man or woman. It is the danger to the public of his or her contagiousness and infections from the standpoint of physical and moral disease.” The South Carolina physician, Robert Wilson, Jr., seconded Shufeldt, warning that “the negro is a public health problem of the highest importance
can scarcely be gainsaid.” Wilson cited a British counterpart, Sir Harry Johnston, who was considered an international authority on Negroes in the Western world. Johnston characterized the Negro as “a hive of dangerous germs [who] perhaps has been the greatest disease-spreader among the other sub-species of Homo sapiens.”

No matter how much rhetorical “fire and brimstone” health, government, and science authorities injected into their public warnings that blacks were a health menace, facts, statistics, and case studies would have to be marshaled to establish the scientific “validity” of their claims (the same, of course, held true for the opponents of such racialism). Because local government and medical examiner mortality reporting, public health survey techniques, and federal census enumeration of births and deaths were only just becoming standardized and expansive, clear patterns of disease, sickness, and mortality for blacks and Americans generally were pieced together from a variety of data. What sufficed for health authorities seeking an immediate, comprehensive explanation for black health inferiority were the clinical impressions of southern physicians and public health workers.

The conceptualization throughout American medical circles of black health in the early twentieth century was shaped primarily by the medical academicians and practitioners of southern elite society for several reasons. Not only did about nine-tenths of blacks reside in the South at this time (1900), but northern medical leaders assumed that their southern white counterparts had effectively observed, diagnosed, and treated blacks throughout the two-century duration of slavery. By World War I leading medical journals of the northern states and national medical organizations regularly published articles by southern medical researchers and public health workers that analyzed burdensome health traits alleged to be unique to Negroes. For example, in 1906 the American Journal of Dermatology & Genito-Urinary Diseases published “Racial Peculiarities: A Cause of the Prevalence of Syphilis in Negroes,” authored by Daniel D. Quillian, an Athens, Georgia, physician. In 1910 the American Medical Association’s prestigious journal published studies by H. M. Folkes, a Mississippi physician, and Thomas W. Murrell, a Richmond physician, on “The Negro as a Health Problem” and “Syphilis and the American Negro: A Medico-Sociologic Study,” respectively.

The studies emerging from the early-twentieth-century South on disease patterns among blacks illustrated the profound distance that existed between southern medical sociology—for Durkheimian-
like “social facts” or generalities were the substance of this medical thought—and the idea that dark-complexioned people suffered equally with others once afflicted. The studies also epitomized the broad utility of racialist conceptualizations of diseases throughout the emergent medical specialities. Indeed, this epidemic paradigm or collective sociomedical imperative that blacks were one with the causative agents of infectious diseases, holds a dominant place in the American medical community through the 1920s.

Quillian’s treatise on syphilis, for instance, smoothly jumps from sociological opinion to clinical conclusions. He stresses that black Americans were natives of tropical and semitropical climates and thus have “sexual instincts developed to a very high degree.” When these instincts combine with the black’s “lax morals and indifference to virtue,” according to Quillian, “the negro as a race is more prone to venereal disease than the white race.” Quillian hops next into the “clinical” realm and back out to epidemiological generalization: “From personal observation I believe that sixty to seventy percent of the blacks in the South have either hereditary or acquired syphilis.”

A few years later Murrell’s treatise on syphilis and blacks appeared in JAMA. The study’s aim was to fill the “lack of statistical material on the subject and the consequent general ignorance” prevalent in the northern “white zones of our country.” He argued that separate racial branches have entirely different evolutionary patterns. Thus, the “knowledge of syphilis as affecting the Caucasian, however profound, will not give one insight into the conditions confronting the negro.”

Murrell then proceeded to describe the sociological development of black Americans, stressing the widely held notion that as a result of the overthrow of slavery the health of blacks had been “crushed.” To Murrell the direct physical effects of emancipation were now at the root of black ill-health. He exhorted that the black “was free indeed . . . free to get drunk with cheap political whiskey and to shiver in the cold[,] free never to bathe, and to sleep in hovels where God’s sunlight and air could not penetrate—absolutely free to gratify his every sexual impulse; to be infected with every loathsome disease and to infect his ready and willing companions—and he did it—he did it all. The result is the negro of 1909, the negro of today.”

The black American in Murrell’s view was now overcrowding the insane asylums and dying off rapidly. “He is, as a rule, but a sorry specimen,” Murrell wrote, “for disease and dissipation have
done their work only too well.” Also, according to Murrell’s sociology of black communities, there was no sensitivity to health or morality among them: “Morality among these people is almost a joke . . . and venereal diseases are well-nigh universal.” This researcher was so convinced of the black American’s physical and social decadence, he could assert: “It is my honest belief that another fifty years will find an unsyphilitic negro a freak . . .”

Other medical racialism emanating from the South early in this century argued that members of the black race possessed exceptional immunities against common ailments. In 1911 a New Orleans physician who had treated about 600 patients for various forms of alcoholism concluded that “no quantity [of alcohol] which [a black] is able to assimilate has the power to produce on his brain and nervous system the profound disturbance commonly observed in the white race under like conditions.”

Modern readers should not underestimate the extent to which syphilis, along with TB, preoccupied the medical and popular mind at the turn of the century; hence, the strong scientific and popular demand for southern medical research on why the disease appeared epidemic among blacks. By 1905 syphilis was attributed to some 125 causes. Even the famed William Osler remarked that “the story of the search for the cause of syphilis is a tale to make the judicious grieve.” Since the fifteenth century, when new directions in medical philology, clinical observation, and pathological anatomy occurred in Western medicine, the syphilis dilemma had ensnared a dominant segment of the medical research community.

Yet it was not until the middle of the nineteenth century that medical research was able to separate syphilis from gonorrhea, and 1905 when protozoologist Fritz Schaudinn and “syphilologist” Erich Hoffman unveiled the causal microorganism: the spirochete, treponema pallidum. Still more research was necessary to sharpen diagnosis of syphilis, most notably Wassermann's (1906) and later Hinton's serological tests. Finally, later in the twentieth century, the modern therapeutic phase or so-called antibiotic revolution was inaugurated by the likes of Ehrlich (the 1900s and 1910s); Fleming, Florey, and Chain (the 1920s and 1930s); and Mahoney (the 1940s).

The ways that the medical community approached black Americans and syphilis during the twentieth-century antibiotic period was shaped largely by the limitations in earlier research tendencies. Three specific aspects of the preantibiotic phase of syphilis research formed the medical profession’s strong predisposition for making and remaking the “syphilitic Negro” concept. First, before
the antibiotic period, the prevalence of syphilis was viewed broadly, through the lens of early international geography of epidemics. This world view of syphilis fit neatly with the continental or geographic concept of races that had been mapped primarily during the eighteenth and nineteenth centuries as Western imperial exploration and colonization expanded.\textsuperscript{63} Indeed, prior to the early twentieth century, syphilis was approached as a devastating worldwide puzzle by the Western medical community and occupied a separate branch of the medical specialties. Typical medical textbooks were divided into separate sections for the major organ systems, which in turn were subdivided into subsections on congenital defects, infections, trauma, and tumors. Syphilis was listed as a separate section as well.\textsuperscript{64}

Second, since the diagnosis of syphilis centered on the array of lesions it produced and was diagnosed mostly by dermatologists, the syphilis specialty, "syphilology," was interwoven with dermatology.\textsuperscript{65} Third, early syphilology also centered on "congenital" syphilis; that is, syphilis contracted by an infant prior to birth.\textsuperscript{66} In the early decades of this century, this form of syphilis was much more loosely defined than in its modern sense. Today it is known that congenital syphilis is acquired solely during the late weeks or months of intrauterine development from an untreated infection in the mother.\textsuperscript{67} But prior to World War II congenital syphilis was frequently classified as interchangeable with "hereditary syphilis": a form of the disease allegedly passed by genotypical traits of the parents and conceivably passable to third generation offspring.\textsuperscript{68}

This universality of the syphilis threat, and its strong dermatological and (reputedly) hereditary features provided a major philosophical foundation for the tendency in modern America to interpret racially any black–white discrepancies in syphilis incidence and mortality. As data on syphilis rates began to build, and with the disease preoccupying increasing numbers of the nation’s medical and public health community, the racialist response to the syphilis problem among blacks branched out.

One of the most active of the northern medical exponents of the racialist view was Dr. Howard Fox, a New York academician. Writing in an international dermatological and syphilological journal in 1912, Fox highlighted a new lesion phenomena to be added to several "dermatological peculiarities of the negro."\textsuperscript{69} He described the abnormal frequency of "annular forms of the papular syphilide... in the negro race," and argued that this manifestation should be included with keloid, elephantiasis, and fibroma “as affections that are especially characteristic of the negro.” It is noteworthy how Fox, like
his southern adherents, easily drew conclusions about the black race generally from observations of a set of their specific patients. This is a classic error in epidemiological technique.⁷⁰ Observe this language to his readers: “[E]very one who has had occasion to see many cases of skin disease in the negro must have been impressed with the frequency and extent of the annular syphilide in the colored race.”⁷¹ In a later study, “Syphilis and the Negro,” Fox again uses broad, racial phraseology: “The age at which infection occurs is apparently earlier in the American negro than in the white race, due to lower standards of morality.” And, “[t]he severity of the disease is in general milder in the negro race.”⁷²

3

The medical and popular racialist explanations for the greater devastation among blacks from infectious diseases like syphilis and TB fueled an opposing intellectual movement. This counterinterpretation came from black physicians, as well as a small but growing community of social scientists and welfare workers. While many among the mainstream medical community accepted that racial susceptibility precluded effective treatment of blacks, the typical black general practitioner refused to give much time to this issue. In addition, the small cluster of the more educated, research-oriented black physicians, conducted clinical studies to refute the racialist position at every opportunity. For example, Daniel Hale Williams, the black surgeon of international renown, published an article in 1900 on ovarian cysts in black women. The purpose of this study was “the refutation of the idea that had been almost universal among surgeons, that colored women did not have ovarian tumors.”⁷³

As for other blacks in the medical fields, they considered controversy over racial influence on disease susceptibility an abstract conjecture of little relevance to the movement for better health and hygiene they were advancing. Typical black medical professionals knew they had little power to curtail racialism in elite medical circles. They concentrated instead on offering whatever resources they could to comfort the disease victims, at the same time remaining academically and politically active in their profession. John A. Kenney, the medical director of Tuskegee Institute, editor of the journal of the black physicians’ National Medical Association (NMA), and a highly regarded professional leader throughout black America, summarized his colleagues’ views in 1911. In “Health Problems of the Negroes,” which he wrote for the Annals of the American Academy of Political
and Social Science, Kenney cited their growing involvement “in the crusade against preventable diseases” as one of the most gratifying developments throughout black America.74 In light of this expanding self-help movement, he found the race debate in medicine essentially worthless:

In many places, without quibbling over such academic questions as whether the Negro is dying as rapidly as some other people, or whether there is some racial inerhency productive of its high mortality, or whether it is due to environment, the race is realizing that its death-rate is high; that certain diseases are taking more than their toll of human life from its ranks, and that many of these diseases are preventable. With this realization, many Negroes have set to work to improve their living conditions and reduce mortality.75

Similar denunciation of the racial susceptibility debate was made a few years later by another eminent black physician and professional figure, Charles V. Roman. A president of the NMA and professor at Meharry Medical School, Roman’s ponderous book, American Civilization and The Negro—The Afro-American in Relation to National Progress (1916) was largely an assault on the racialist and eugenics scholarship of the day. According to Roman, this presumably scientific literature always rendered blacks inferior. “In medicine,” he wrote, “the Negro is alike blameworthy for anaphylaxis and immunity. If he is susceptible to disease (as tuberculosis), he is a weakling; if he is not susceptible (as hookworm), he is a menace.” Roman’s book then offered a procession of cultural achievements by his and other dark races, as a counter to “a conspiracy of silence in facts creditable to the race.”76

In the social science community, phenotypical inferiority of the Negro race was one of the burning issues prior to World War I. The 1906 Atlanta University Conference for the Study of Negro Problems focused on “The Health and Physique of the Negro American.” This conference’s primary aim was to bring before the public and those “who are eagerly and often bitterly discussing race problems” the recent advances in “anthropological science.”77 The proceedings of the conference contained excerpts of essays and printed speeches by some of the nation’s newly rising anthropological and sociological thinkers, such as Herbert A. Miller, Franz Boas, and Monroe N. Work, who contested the evolutionist idea of an amorphous, inferior Negro race.78 It was the participants of this Atlanta conference who raised
one of the earliest challenges to the scientific validity of Robert Bennett Bean’s craniometry. Miller summarized the thrust of the conference with the statement that only “until different races have had exactly the same history can any valid conclusion be drawn as to their relative psychophysical capacity if mere observation is used.”

Despite their confidence that the medical and public idea that blacks possessed greater racial susceptibility to communicable diseases would some day be discarded, black physicians faced extreme pressure from their larger professional community to curtail the devastation from these diseases. Kelly Miller, a nationally recognized black educator and polemicist (and from 1907 to 1919 dean of liberal arts at Howard University), repeatedly articulated the almost religious importance black professionals and civic leaders attributed to the every move of black physicians. In 1908 he wrote of the particular seriousness of “diseases of a pulmonary character” affecting black city-dwellers. Miller found black Americans constantly querying “[w]here is to be found deliverance from the effects of this scourge?” He answered time and time again in his many speeches and published works that the black doctor would champion this effort: “[T]he Negro physician must treat every form of disease that human flesh is heir to.” Since, according to Miller, “[o]ne touch of disease [like TB] makes the whole world kin, and also kind,” the black physician held national importance. Indeed, Kelly emphasized “during the entire history of the race on this continent, there has been no more striking indication of its capacity for self-reclamation and of its ability to maintain a professional class on the basis of scientific efficiency than the rise and success of the Negro physician.”

Most indicative of the divergent responses within the black and white southern communities to the infectious disease problems of blacks was the massive public health voluntarism that emerged throughout black urban communities. At the beginning of this century, black health professionals and civic leaders were painstakingly knitting together a network of small hospitals and infirmaries, as well as public-oriented professional associations, medical schools, and nurses’ training facilities. By 1906 forty voluntary hospitals and smaller health centers had been established, some of which trained nurses, as well as five medical schools. By 1912 the number of health care facilities had increased to sixty-five. Most of these institutions were located throughout the South.
Also in the early 1900s there were already mass drives throughout the nation’s black urban communities to build public health and personal hygiene consciousness. Indeed, the medical facilities and professional training institutions were generally viewed by both black medical professionals and black communities as part of this public health voluntarism.

The NMA, for instance, grew tremendously between 1904 and 1912 from fewer than 50 members to 521. This growth was a result of the popularity of the NMA’s goals to organize black physicians, dentists, and pharmacists; it also would “insure progressiveness in the profession,” and “help improve living conditions among the Negro people by teaching them the simple rules of health.” The black hospitals were also viewed primarily as an answer to the urgent public health needs of black communities. As the prominent NMA leader John A. Kenney wrote in 1912, “Another element in the work of improving the health of the Negroes is the rise of the Negro hospitals.” Even the journal of the NMA was intended more to raise the public’s consciousness of preventive health measures, than to report specialized medical research and practice. John Kenney emphasized this in his 1912 book The Negro in Medicine. The JNMA “is especially devoted to the interests of Negro physicians, surgeons, dentists and pharmacists;” he wrote, “but it is so planned and written that it is of general interest to nurses, teachers, ministers, and any intelligent laymen who are interested in the progress of the race.”

Even more important than the progressivism within the black medical profession, and generally overlooked by American medical history scholars, is the outpouring of public interest throughout educated sectors of black communities for any health campaigns or professional medical activities relating to TB, venereal disease, or other major health problems plaguing these communities. At its national meetings, the NMA had at least one public session “when subjects of popular interest are discussed in simple language.” Topics ranged from the “cause, prevention and treatment of TB,” to infant mortality and “the proper care and feeding of infants.” Kenney remarked that these presentations were most popular and “have always been given in crowded halls.”

In addition to lay activism connected with the NMA, organized public health campaigns headed by local black churches, insurance companies, and colleges emerged throughout the nation’s black city communities. In 1905 the Men’s Sunday Club was organized in Savannah, Georgia, which held regular meetings to address improving community health. About 200 people would usually attend to
hear local black physicians on health matters. According to its president, Monroe N. Work, the Club proved that “the gospel of health could be carried directly to the colored people and that they were ready to hear and to put into practice what was told to them.”

In 1908 the all-black Knights of Pythias established a bathhouse and sanitorium in Hot Springs, Arkansas, where, by 1911, thousands came for “water cure” treatments. A year later anti-TB leagues or campaigns were formed in Portsmouth, Norfolk, and Richmond, Virginia. The far-reaching activities of the Richmond league were described as follows:

The third Sunday in January, 1910 was observed as tuberculosis day. A sermon on tuberculosis was preached in nearly every colored church in Richmond, and literature bearing on the subject was distributed. . . . A registered nurse, as chairman, did very important work by affiliating with the city health authorities in hunting up tubercular patients and providing proper treatment. The committee divided the city into districts and nurses were assigned to each. . . . Food, clothing, medicine, and even fuel has been furnished for the sick. . . . The membership of the league is about four hundred.

During 1913 still another community health group emerged in Virginia, the Negro Organization Society of Virginia. Endorsed by the Virginia State Department of Health and local voluntary agencies and health bureaus, the Society according to one health official, “demonstrated the value of a popular periodic campaign for a general cleaning-up of homes, lots, fields, and the community at large in all parts of the state.”

In addition to public health campaigns, the lay black community provided enthusiastic financial and political support for their local black hospitals and nurses’ training facility. Black women’s clubs were especially involved in this area. One German overview of black life published in 1911 was impressed that there were about 100 “orphanages and asylums for widows, cripples and aged, founded by Negroes.”

By the mid-1910s the vigorous mutual interest of both lay blacks and black medical professionals in reducing the damage of infectious diseases, preventable infant illnesses, and unsanitary living conditions, was peaking. In fact, Booker T. Washington capitalized on the projects and public spirit generated by these earlier efforts, when he initiated the historic “Health Improvement Week” move-
ment in 1915. His idea became the Negro Health Week movement, a nationwide campaign centered at Tuskegee Institute. Each April black community leaders in education, health, and church affairs organized a program to increase public awareness of health problems and self-improvement measures for the school, home, and communities. The Negro Health Week movement gained increasing public support throughout the 1920s and 1930s including assistance of the United States Public Health Service.

Although this early-twentieth-century black health movement provided the seed for community-based or “indigenous” black community health mobilization, it had fundamental weaknesses that limited its effectiveness in reducing major infectious diseases and health problems of black populations. The immediate shortcomings were the institutional and technical deficiencies of black hospitals. Most of the pre–World War I black hospitals were relatively small, and focused on providing surgical services and opportunities for black physicians’ and nurses’ training, but not preventive health care programs. Physicians at these voluntary institutions, like many of their white counterparts across the nation, disdained contagious disease cases.

As an example, the Perry Sanitorium in Kansas City, Missouri, had just twenty beds by 1911 and 90 percent of its cases were surgical. The twelve-bed Fair Haven Infirmary in Atlanta functioned primarily as a surgical site for local black physicians as well as white surgeons with black patients. Through the 1930s the larger black hospitals in major cities—for example, Provident Hospital in Chicago, Mercy Hospital in Philadelphia, and Flint-Goodridge Hospital in New Orleans—received increasing support from major philanthropies. The overall function of these institutions, however, remained limited to what Michael M. Davis called the “educational enterprise.”

A second immediate barrier to expanding the early black health movement was that the southern medical establishment was unsupportive of both the black lay-inspired health institutions and the black medical professions’ hospital and medical school projects. Public health officials occasionally endorsed ceremonial activities like the health week campaigns but not any sort of build-up of a permanent health care infrastructure for black communities; that is, an infrastructure with substantial revenues, ongoing screening and treatment programs and institutions, and capable black administrative leadership.

The chasm between the black community’s voluntary health
network, and the larger medical profession and public health officialdom throughout the pre–World War I South was clearly evident when the all-white Southern Medical Association convened in Atlanta during November 1916. The major issue addressed at this conference was the TB epidemic throughout the South’s black community. A troubled audience of physicians, many of whom were directors of TB sanitoriums, gathered to hear and discuss a study by Dr. Martin F. Sloan, “The Urgent Need of Hospital Facilités for Tuberculous Negroes.” The head of the Fudowood Sanitorium in Townsend, Maryland, Sloan was considered one of the region’s most able authorities on TB treatment and care. Using vital statistics, information on TB facilities provided by the National Association for the Study and Prevention of Tuberculosis, as well as his own questionnaire survey of twenty local anti-TB organizations throughout the southern states, Sloan painted a grim outlook for the white South. He cited government census data for Kentucky, Maryland, North Carolina, and Virginia, the only southern states then in the registration area, which recorded nearly 4,900 deaths of blacks from TB in 1914. In southern cities he estimated that black mortality from TB was three times that of whites, and in Baltimore alone 399 blacks died from the disease during just the first seven months of 1916.09

Besides the high black mortality rate, Sloan cited two other factors that intensified the black TB crisis: the biological and sociological susceptibility of blacks to TB, and the daily economic and social interaction between whites and blacks that made the latter group a deadly conduit of TB into the white community. “The susceptibility of the Negro to tuberculosis is generally well known,” he remarked, “[a]dd to his inherited susceptibility an unusual fondness for alcoholics and retarded mental development, and the host is prepared for the ubiquitous and energetic tubercle bacillus.”100

Sloan emphasized the sociological dimension of the TB crisis posed by blacks, offering cold population statistics and menacing examples of how infections could be transmitted during ordinary contacts between black and whites. Roughly 8.8 million or 90 percent of the nation’s blacks resided in the South. Of the several million black workers within the South, over 2.8 million were in the agricultural sector; thus, they would “handle directly the [food] provisions of millions of consumers.” Even worse than the relationship of blacks to food production, according to Sloan, was “that the Negro comes in closer contact with the white population than this, for 368,124 were laundresses and laundymen; 22,534 barbers and hairdressers; 2,666 bartenders; 8,232 door boys and bell boys; 3,850