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# The South Carolina Sanatorium: The Landscape of Public Healthcare In the Segregated South

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THE SOUTH CAROLINA SANATORIUM  
THE LANDSCAPE OF PUBLIC HEALTHCARE IN THE SEGREGATED SOUTH

by

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Bachelor of Arts  
Florida State University, 2011

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## ABSTRACT

This site-specific study examines the development of the South Carolina Sanatorium, which operated as a state-funded tuberculosis treatment center between 1915 and 1953. Using the South Carolina Sanatorium as a case study, this thesis draws upon the history of the Progressive Era, medicine, and architecture to analyze the influence of segregation on public healthcare in the South. By looking at the development of individual buildings and the site as whole, the built environment of the South Carolina Sanatorium is used as a framework to assess the effects of segregation on tuberculosis treatment in South Carolina.

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## INTRODUCTION

Tuberculosis became a disease of the past in American's collective memory after the development of effective antibiotic treatments in the 1950s. Today, few fear the ferocious cough and blood stained sputum that defined "consumption," as it was called prior to Robert Koch's discovery of the tubercle bacillus in 1882. Yet, in the nineteenth century tuberculosis was responsible for one in every five deaths. It was a disease everyone feared. By the turn of the twentieth century, tuberculosis infections declined in the general population because of the improved living conditions accompanying the rise of the middle class. Medical advances increased the understanding of the disease, minimizing the spread of tuberculosis through contagion. But for the impoverished populations of immigrants and the racial underclass, tuberculosis continued to spread rapidly through the increasingly overcrowded slums of the industrial age.<sup>1</sup>

Despite South Carolina's principally rural population, tuberculosis was a considerable public health concern throughout the first half of the twentieth century in large part because of the substantial African-American population living in poverty under the Jim Crow system. In a 1906 national survey of nine American cities, Charleston, South Carolina, ranked the highest in African-American tuberculosis deaths, estimated at

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<sup>1</sup> Sheila Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: BasicBooks Inc., 1994), 2.

680 per 100,000 populations.<sup>2</sup> As the Progressive Era called for an increasing level of government responsibility for public health, sanatoriums became the favored prescription for tuberculosis treatment and disease control.<sup>3</sup> In the midst of the national sanatorium trend, the State Board of Health opened the South Carolina Sanatorium in 1915. The property was originally comprised of one open-air pavilion with the capacity for sixteen white male patients. In 1953 the state transferred responsibility to the sanatorium's board of trustees, greatly reducing the political influence over the property. By that time the facilities could accommodate over 600 patients with separate spaces designated by gender, health, and race. Through examining the development of the South Carolina Sanatorium, politically, socially, and architecturally, this thesis will explore the relationship between government and public healthcare in the segregated South.<sup>4</sup>

Ultimately, the built environment of the South Carolina Sanatorium illustrates the link between tuberculosis treatment, architecture, and segregation in the first half of the twentieth century. Addressing an absence in previous studies, this thesis examines the significance of segregation as a contributing factor to the built environment of sanatoriums. Exploring the relationship between landscapes and healthcare more broadly, architectural historian Annmarie Adams defines architecture as an important part of medical technology. She argues that physical structures and landscapes significantly

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<sup>2</sup> Samuel Roberts, *Infectious Fear: Politics, Disease, and the Health Effects of Segregation* (Chapel Hill: University of North Carolina Press, 2009), 28.

<sup>3</sup> Ruth Clifford Engs, *The Progressive Era's Health Reform Movement: A Historical Dictionary* (Westport, CT: Praegar Publications, 2006), 292.

<sup>4</sup> This thesis uses the British spelling of "healthcare" as opposed the American separation of the words "health" and "care." British welfare literature defines "healthcare" as a public service. Since this thesis analyzes a period in American *public* health services, I have chosen to use the term "healthcare" for its greater association to a welfare system.



shape the experience and quality healthcare.<sup>5</sup> Additionally, analyzing the process in which healthcare facilities were designed and built further illuminates the relationship between medicine and society. Experts (architects and medical professionals), users (patients), and social pressures influenced the designing process both formally and informally.<sup>6</sup> These multifaceted influences are legible in the built environments of hospitals and significantly shaped the experience and quality of healthcare. Taking a southern focus, the history of the South Carolina Sanatorium demonstrates the statewide negotiations between the social, political, and personal interests that influenced the development of a segregated public healthcare institution. Just as these interests groups and social pressures shaped the built environment of the South Carolina Sanatorium, the built environment in turn greatly influenced the healthcare of state tuberculosis patients.

In addition to the relationship between architecture and tuberculosis treatment, this thesis also builds upon the history of disease contextualized within the Progressive and Jim Crow eras. Early histories of tuberculosis privileged narratives of scientific progress. Scientists and doctors often play leading roles in histories of disease, depicted as engineers of progress.<sup>7</sup> Until recently, the literature of tuberculosis largely overlooked the essential social construction of disease. Shelia Rothman's *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (1994) focuses on the experience of illness rather than retelling the dominant narrative of medical progress. As one of the first works to privilege the voices of the ill, Rothman

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<sup>5</sup> Annmarie Adams, *Medicine by Design: The Architect and the Modern Hospital 1893-1943* (Minneapolis: University of Minnesota Press, 2008), 129. For further reading on the history of medicine and architectural design see J. T. H. Connor's "Hospital History in Canada and the United States" (1990).

<sup>6</sup> Adams, *Medicine by Design*, xix.

<sup>7</sup> For further reading see Selman Waksman, M.D. *The Conquest of Tuberculosis* (1964). In 1944 Waksman's lab discovered the first effective biomedical treatment for tuberculosis, streptomycin.

explicitly examines the role of class and gender in the treatment of tuberculosis. Utilizing this social framework by which a disease is defined and treated, Rothman illustrates the powerful relationship between medicine and society.<sup>8</sup> Illuminating the experience of tuberculosis through diaries, letters, and other personal accounts, Rothman greatly expands the source material used to interpret the history of tuberculosis. Although providing a more inclusive discussion of tuberculosis by emphasizing the voices of the sick, Rothman acknowledges the racial and regional limitations of her work, which focuses nearly exclusively on white northerners.<sup>9</sup>

The relationship between race and disease is often absent from the early histories of tuberculosis and broader studies of disease. Yet, blacks were disproportionately affected by tuberculosis. In 1900 blacks comprised 11.6 percent of the national population but contributed 20.12 percent of all tuberculosis deaths, nearly twice that of the national rate.<sup>10</sup> Increased housing regulations, public health initiatives, and the rising middle class contributed to a continuous decrease in the tuberculosis mortality rate amongst the white population. However, the mortality rate among African Americans remained high into the mid-twentieth century. In South Carolina, for example, 913 of the 1,195 tuberculosis deaths reported in 1933 came from the African-American population, over three times that of the white mortality rate.<sup>11</sup> Dedicated to discerning the relationship between race and tuberculosis, Samuel Roberts' *Infectious Fear: Politics, Disease, and the Health*

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<sup>8</sup> Rothman, *Living in the Shadow of Death*, 3.

<sup>9</sup> For further reading on the social construction of disease see Susan Sontag, *Illness As Metaphor* (1978). Sontag asserts the language of disease greatly influences the social treatment of the ill, both contemporaneously and throughout historical interpretation. For further reading on the patient experience of tuberculosis see Barbara Bates, *Bargaining for Life: A Social History of Tuberculosis* (1992). *Bargaining for Life* is one of the earliest works in the history of disease to use an interpretive framework of race, class, and gender. *Bargaining for Life* focuses exclusively on tuberculosis treatment in Philadelphia.

<sup>10</sup> Roberts, *Infectious Fear*, 27.

<sup>11</sup> "Facts About TB in South Carolina," c. 1940, Speeches and Reports, State Park Health Center Collection, South Carolina Department of Archives and History (SCDAH).

*Effects of Segregation* (2009) explores the politics of the Progressive Era in relation to segregation and public healthcare. Examining the Jim Crow era politics of both white and black communities in Baltimore, Roberts situates the tuberculosis experience in a “landscape of health.” Rather than a tangible built environment, Roberts defines the landscape of health as a product of demographics and politics. Roberts argues the distribution of health inequality associated with racial underclasses is intrinsically linked to the broader political economy.<sup>12</sup> By expanding Roberts’ definition of the landscape of health, the history of the South Carolina Sanatorium uses the built environment as another source to interpret the relationship between race and tuberculosis treatment.

In combination with the social and political insights into the history of tuberculosis, material culture provides a valuable framework in which to better understand the history of the South Carolina Sanatorium. Katherine Ott’s *Fevered Lives: Tuberculosis in American Culture since 1870* engages the material environment to explore the cultural construction of disease. Ott argues “sites of illness” provide context for understanding the experience of illness and the relationship between the ill and their caregivers.<sup>13</sup> From sputum cups to photographs of loved ones, the material objects that filled these sites of illness culturally contextualize the experience of suffering from tuberculosis. Building upon this framework, the landscape of southern sanatoriums must be examined in relation to the prevailing culture of Jim Crow in the twentieth century. As sites of illness in the segregated South, sanatoriums are often discussed in terms of either mono or multiracial institutions. However, this notion of a strict dichotomy obfuscates the political and social negotiations that shaped race relations within multiracial facilities.

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<sup>12</sup> Roberts, *Infectious Fear*, 70.

<sup>13</sup> Katherine Ott, *Fevered Lives: Tuberculosis in American Culture since 1870* (Cambridge, Massachusetts: Harvard University Press, 1996), 4.

Here architecture provides a new framework in which to interpret the quality of the healthcare provided at the South Carolina Sanatorium as a public institution serving both white and black communities.

A comprehensive history of the South Carolina Sanatorium has not been done to date. Much of the research in this thesis draws upon the *Annual Reports* of the institution compiled for the South Carolina State Board of Health between the years 1914-1968. Other sources include historic photographs, administrative notes and speeches, articles from *The State* newspaper, and the South Carolina's State Historic Preservation Office resource files. With the sanatorium's government affiliation, the South Carolina Department of Archives and History holds the largest collection of material for the site. Also located in Columbia, South Carolina, the Richland Library Walker Local History Room and the University of South Carolina's Caroliniana Library proved helpful resources as well. One apparent void in the archival record of the South Carolina Sanatorium is the absence of a detailed site plan of the property. To address this limitation, I created a basic map drawing upon photographic and textual evidence (Figure 2.1). This map is referenced throughout the thesis to provide a visual orientation for the spatiality of segregation at the sanatorium.

The thesis is divided into two chapters that address the themes of disease, race, and public healthcare. Chapter 1 discusses the national context of the antituberculosis movement, including the advances in tuberculosis treatment like the discovery of disease's origins and the development of specialized treatment facilities. Additionally, this chapter explores the social and political relationship between the Progressive Era

reform movement, the codification of Jim Crow, and the treatment of tuberculosis at the beginning of the twentieth century.

Chapter 2 examines the development of the South Carolina Sanatorium as a public institution between the years of 1915 to 1953. The chapter is then divided into six loosely chronological sections. Rather than dictate a strict institutional history, each section examines the development of a specific building or group of buildings on the site. Each building reveals a different aspect of the relationship between the political, social, and medical motivations that shaped tuberculosis treatment in South Carolina. The chapter opens by analyzing the origins of the South Carolina Sanatorium and the influences of medical technology and segregation, both racial and medical, on the development of the institution's landscape. Palmetto Hall, the first African-American ward, is the subject of Section 2.1. This section looks at the early strategies of segregation on the site and the subsequent inequalities. Section 2.2 surveys the addition of Campbell Hall, which highlights the improving medical technology of the 1920s and women's role as public healthcare advocates. Discussing staff housing on the property, Section 2.3 examines the institution's social structure and segregation amongst the staff. Section 2.4 assesses patient involvement in the development of the sanatorium with the examination of the Earnest Cooper Community Building. Exhibiting the change in segregation policies at the site in the late 1930s, Section 2.6 chronicles the effects of the Public Works Administration (PWA) Building on patient care. As a final point, Section 2.7 looks at the New Negro Women's Ward built in 1954. This modern building demonstrates the changing medical and social influences on the site, such as antibiotic treatments and the rising animosity against the Jim Crow system. Lastly, the conclusion

addresses the changes at the South Carolina Sanatorium after privatization of tuberculosis treatment in South Carolina and the decline of the disease in the state's population.

All of the architectural elements discussed in Chapter 2 represent the influences of medical advancements, Progressive Era reforms, and segregationist ideals on tuberculosis treatment during the first half of the twentieth century. By looking at the built environment of the South Carolina Sanatorium we can see how architecture and the use of space facilitated the inequality of public healthcare in the segregated South.

## CHAPTER 1

### DISEASE, RACE, AND PUBLIC HEALTHCARE IN THE PROGRESSIVE ERA

Public healthcare in South Carolina was greatly influenced by broader national trends at the onset of the twentieth century, including advances in medical technology, Progressive Era social reforms, and the codification of racial segregation.<sup>14</sup> Beginning with the disease itself, contextualizing the history of the tuberculosis is essential to understanding South Carolina's relationship to the sanatorium movement. Often described as "the great white plague" or "the white death," consumption was never confined by geographic or temporal boundaries. Unlike other diseases that offered their victims a quick release from suffering, consumption was a gradual process of wasting away.<sup>15</sup> While acknowledging the disease's ancient roots, consumption gained new notoriety as a harbinger of death throughout the eighteenth and nineteenth centuries as the Industrial Revolution spawned rapid urbanization. Densely populated urban environments, poor housing conditions, and confined workspaces increased consumption

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<sup>14</sup> International hospital design and global advances in tuberculosis treatments also influenced the sanatorium movement in America. Thirty years prior to the discovery of tubercle bacillus, Swiss physician Hermann Brehmer was treating consumption patients with a regimen of fresh air, rest, and nutrition in the Swiss Alps. Brehmer's Gomersdorf Camp greatly influenced American physician Edward L. Trudeau, who founded the first sanatorium in the U.S. in 1885. As the sanatorium movement developed in the twentieth century, doctors and architects from Western Europe, Canada, and America continued to influence a nearly unified Western medicine approach to treating tuberculosis. Annmarie Adams, Kevin Schwartzman, and David Theodore, "Collapse and Expand: Architecture and Tuberculosis Therapy in Montreal, 1909, 1933, 1954," *Technology and Culture* 49, no. 4 (2008): 914.

<sup>15</sup> Rothman, *Living in the Shadow of Death*, 13.

mortality rates in industrializing areas. However, without a substantiated microbial understanding of contagion, the medical profession proposed a hereditary explanation for the disease. As heredity could not account for all cases of consumption, doctors also considered the behavioral practices of unhealthy living a causal factor. The notion of “health,” unlike modern definitions, encompassed both physical and moral components. Many nineteenth century doctors and social reformers believed immoral behavior caused disease. Drinking, smoking, and sexual promiscuity were among many actions deemed illicit enough to trigger the dreaded consumption.<sup>16</sup>

By the mid-nineteenth century, scientists gradually questioned hereditary and moral rationalizations of disease. Louis Pasteur’s preclusive work in microbiology and bacteria studies provided the foundation to study both the causes and cures for infectious diseases. Robert Koch, a German general practitioner, was the first to decipher the relationship between bacteria and consumption. By testing samples from consumption victims on guinea pigs and rabbits, Koch isolated the bacterial strand he named tubercle (rod-shaped) bacillus. Consumption was thus proven to be a communicable disease. Koch presented his findings to the Berlin Physiological Society in 1882. Reports of the discovery of the tubercle bacillus circulated amongst the international medical community rapidly and spread across popular news outlets in Europe and the U.S within the month. Some praised Koch for his breakthrough in microbial studies. Others questioned his findings. Despite mixed opinions, the entire medical community wondered

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<sup>16</sup> Thomas Dormandy, *The White Death: A History of Tuberculosis* (New York: New York University Press, 2000), 40-45.



what this would mean for the prevention and treatment of the ancient, yet newly redefined disease: tuberculosis.<sup>17</sup>

Koch's discovery of the tubercle bacillus transformed the medical and social conception of the disease. Precipitated by Koch's discovery, the term "tuberculosis" largely replaced "consumption" by the turn of the twentieth century. Despite this change in vocabulary, leading medical scholars continued to question the principle of communicable disease. Based in part on the notion of hereditary predispositions to disease, studies of scientific racism and eugenics proliferated at the end of the century. A leading opponent to the notion of communicable disease, Frederick Hoffman's *Race Traits and Tendencies of the American Negro* (1896) created a template for racialized statistics and a standard for extinctionist scholarship that lasted well into the twentieth century.<sup>18</sup> Utilizing examples from around the Atlantic World, including Charleston, South Carolina, Hoffman asserted "...race and heredity [were] the determining factors in the upward and downward course of mankind," including the susceptibility to disease.<sup>19</sup> Hoffman theorized the black populace's increase in consumption rates post-Emancipation were a direct cause of removing the paternal protections of slavery. As demonstrated by Hoffman, employing disease theory to "prove" racial hierarchies was one strategy adapted by white supremacist to legitimize segregation and other forms of racial oppression.

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<sup>17</sup> Dormandy, *The White Death*, 128-134. For further reading on Robert Koch and contextualizing the scientific community of the late nineteenth century see Thomas Brock's *Robert Koch, A Life in Medicine and Bacteriology* (1999).

<sup>18</sup> Roberts, *Infectious Fear*, 48.

<sup>19</sup> Fredrick L. Hoffman, *Race Traits and Tendencies of the American Negro* (New York: Macmillan & Co., 1886), 73, 310. Hoffman believed his German citizenship and medical training provided his work an unbiased perspective on American race relations. Preaching Aryan racial superiority, *Race Traits and Tendencies of the American Negro* spoke to the international trends of social Darwinism and eugenics that proliferated at the end of the nineteenth century and well into the twentieth century.

Along with many social reformers and African-American intellectuals, W.E.B. Du Bois rejected Hoffman's assertions of physiological predispositions to disease. Rather, Du Bois favored an environmental and socioeconomic explanation for the rise of tuberculosis amongst blacks at the turn of the twentieth century, more in line with Koch's notion of a communicable disease.<sup>20</sup> Attacking Hoffman's irresponsible use of statistics, Du Bois sought to refute the assertion of racial susceptibility to diseases. Instead, Du Bois argued that the assumptions of racial inferiority were constructed manifestations of the politically and economically empowered race. Du Bois contended:

Particularly with regard to consumption it must be remembered that Negroes are not the first people who have been claimed as its peculiar victims; the Irishman were once thought to be doomed by that disease – but that was when Irishmen were unpopular.<sup>21</sup>

Socioeconomic arguments, like Du Bois's, brought the medical debates of race and disease in conversation with the rapidly changing landscape of health during the formation of the Progressive Era.

Usually defined between the years of 1890 and 1920, the Progressive Era is noted as a period of great social and political reform aimed at increasing the standard of living as well as improving government accountability and responsibility. Public health campaigns, including the antituberculosis movement, linked these issues together. Reformers believed social ills, such as poverty and disease, could be overcome through legislative reform, public welfare programs, and educational outreach.<sup>22</sup> Women were active leaders and participants in the political and social reforms of the Progressive Era. Even without the right to vote, women shaped public policy through clubs and

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<sup>20</sup> Environmental arguments were also used by white supremacists to account for higher tuberculosis rates among blacks; however, they did not define the environment by socioeconomic factors. Rather, poor personal and household hygiene was attributed to the concept of the intellectual and moral inferiority of minority races. Roberts, *Infectious Fear*, 53.

<sup>21</sup> W.E.B. Du Bois, *The Philadelphia Negro: A Social Study* (Boston: Ginn & Co., 1899), 160.

<sup>22</sup> Rothman, *Living in the Shadow of Death*, 183.

organizations at the national and local level, such as the Young Women's Christian Association and Jane Addam's Hull-House. Additionally, Progressive Era reformers encouraged the rise of professional women in specialized fields, such as social work and nursing. As professionals and as activists women helped define the political and social agenda of reform in the early twentieth century. They also influenced the architectural landscape the Progressive Era, including sites like the South Carolina Sanatorium. Tenement houses, playgrounds, and hospitals were just a few of the built elements that helped implement Progressive ideals of healthy and enlightened lifestyles in American communities. Although men dominated the architectural profession, women nonetheless shaped the built environment of the Progressive Era by influencing local politics, fundraising for building projects, and managing the organizations that created and used these community spaces.<sup>23</sup>

As a part of this larger trend in public health, the antituberculosis movement of the Progressive Era advocated for a combination of legislation, education, and medical treatment to combat the disease.<sup>24</sup> Antituberculosis initiatives were strongest in New York, Pennsylvania, and other industrial areas, but efforts could be seen across the country by the early 1900s. Common legislative actions aimed to prevent the spread of disease, ranging from stricter guidelines for the pasteurization of milk to legal penalties

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<sup>23</sup> Daphne Spain, *How Women Saved the City* (Minneapolis: University of Minnesota Press, 2001), 237.

<sup>24</sup> Michael Teller, *The Tuberculosis Movement: A Public Health Campaign in the Progressive Era* (Westport, Connecticut: Greenwood Press, Inc., 1988), 222-224. Teller argues the combination of legislation, education, and medical technologies make the anti-tuberculosis movement the first modern public health movement in America. Teller also argues the anti-tuberculosis movement was primarily a humanitarian effort. Historians like John Whiteclay Chambers II have since argued that political, racial, and economic factors need to be attributed to the actions of Progressive Era reformers. The primary sources used in this thesis support the subsequent argument.

for spitting in public spaces.<sup>25</sup> Educational efforts promoted the public understanding of communicable disease through informative pamphlets, silent films, and community outreach programming. Lastly, the antituberculosis movement advocated for both state and privately operated facilities dedicated to the treatment of tuberculosis patients: sanatoriums.

A product of the built environment of healthcare during the Progressive Era, sanatoriums were specialized hospitals associated with the long-term care of tuberculosis patients. With no medical cure for tuberculosis, the facilities were designed to encourage remission of the disease by providing patients with a regimen of fresh air, rest, nutritious food, and moderate exercise. Adhering to these principles, Edward Trudeau founded the first American sanatorium in Saranac Lake, New York in 1885. Modeled after the architectural design of Trudeau's Adirondack Cottage Sanatorium, many sanatoriums prominently featured screen porches and large windows in order to provide patients with the medically recommended fresh air and sunshine. Often in rural settings, sanatoriums also isolated the tuberculous from healthy populations.<sup>26</sup> Sanatoriums were more than repositories for the terminally ill. These hospitals incorporated advances in modern medicine into their design and functionality. Sanatorium construction burgeoned nationally in the first two decades of the twentieth century. In 1900 the National Association of the Study and Prevention of Tuberculosis (NASPT) estimated a national

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<sup>25</sup> Bovine tuberculosis, a strand of the tuberculosis bacillus found in cows, is communicable to humans through digestion of infected milk and meat. Sanatoriums, including the South Carolina Sanatorium, often had their own dairies to reduce the risk of exposure to bovine tuberculosis. Teller, *The Tuberculosis Movement*, 18.

<sup>26</sup> Edward Trudeau continued as a leader in the anti-tuberculosis movement, helping to found the National Tuberculosis Association (NTA) in 1904. The NTA was an instrumental advocate for the public funding sanatorium construction, helping spark the sanatorium boom in the early twentieth century. Engs, *The Progressive Era's Health Reform Movement*, 331-333.

total of 19 sanatoriums and 1,450 patient beds. By 1920 the number grew to 407 sanatoriums and 48,596 patient beds.<sup>27</sup>

The sanatorium movement, however, did not spread evenly across the country. The dense population and industrial centers of Northeast made tuberculosis treatment facilities a high priority. Under the contemporary guidelines for tuberculosis care the moderate climate of the Midwest provided ideal locations for treatment, also sparking a boom in sanatorium construction there.<sup>28</sup> Tuberculosis patients in the South, however, faced greater challenges finding accessible treatment. The South's rural demographics made it difficult for any one sanatorium to effectively serve large portions of the geographically dispersed ill. In addition to an insufficient number of facilities, the social, political, and economic barriers of the Jim Crow system further hindered access to tuberculosis treatment for the black communities across the South. Demonstrating the gross inequality of public healthcare, of the 4,130 beds reported available in southern public sanatoriums in 1917, only 114 beds were available for black patients.<sup>29</sup>

Both white and black public health advocates saw the need for expanding tuberculosis treatment to African-American populations; however, the question remained how to provide these services. One option was to provide entirely separate state operated sanatoriums. Virginia was the first state to provide a sanatorium solely for black patients, opening the Piedmont Sanatorium for Negroes in 1917. Maryland followed this model of segregation, opening the Henryton State Sanatorium for Colored Consumptives in 1923.<sup>30</sup>

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<sup>27</sup> Figures account for construction of facilities, but they do not take into account closings. Figures refer to both public and private institutions. Roberts, *Infectious Fear*, 174.

<sup>28</sup> Rothman, *Living in the Shadow of Death*, 19, 203.

<sup>29</sup> Roberts, *Infectious Fear*, 174.

<sup>30</sup> Private sanatoriums also dealt with the question of segregation. Private donors and community organization in Texas, Colorado, and North Carolina opened large sanatoriums specifically for the black

Although opposition most certainly existed, members of the black community in both Virginia and Maryland also supported the creation of segregated sanatoriums as a means to provide access to healthcare.<sup>31</sup> While the vast majority of African Americans lived in the South prior to World War I and the onset of the Great Migration, northern cities also faced a similar question of segregation and healthcare. After the founding of an African-American municipal tuberculosis clinic in Chicago *The Chicago Defender* declared: “the Colored people... would rather die as they have been than to be Jim Crowed” into segregated facilities. “Give us a clinic for all the people, we ask nothing more and will accept nothing less.”<sup>32</sup> For sanatoriums and clinics opening across the country, the issue of race and healthcare was a constant concern.

Along with the sanatorium movement, the entrenchment of segregation at the turn of the twentieth century deeply influenced the development of South Carolina’s public healthcare. After years of weakening the comprehensive reforms of Reconstruction, South Carolina adapted a new constitution in 1895 that formally codified segregation in education. This established a precedent for mandating segregation in places of work, recreation, transportation, and hospitals. In 1896, one year later, segregation was legally justified at the national level. The Supreme Court ruled in *Plessy v. Ferguson* that racial segregation did not conflict with the Constitution so long as segregated facilities were

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community. Financial difficulty was common. Other states had smaller private institutions, clinics, or dispensaries accessible to the black community. Roberts, *Infectious Fear*, 102.

<sup>31</sup> Lindset Dene Gertz, “The Tuberculosis Experience of African Americans in Virginia,” University of Virginia, Web, 20 November 2012 <<http://www.faculty.virginia.edu/blueridgesanatorium/piedmont.html>>. Roberts, *Infectious Fear*, 173. Like the Gertz website, many of the resources available on the history of southern sanatoriums are not published in academic presses. There is an apparent trend in creating websites and wikis (collaborative websites) to document the history of medical institutions, such as asylums and sanatoriums, across the US.

<sup>32</sup> “A Jim Crow Clinic for Colored Folk,” *Chicago Defender*, 14 January 1911.

“separate but equal.”<sup>33</sup> As seen by the architectural record of the South Carolina Sanatorium, the promise of “separate but equal” was not upheld with regards to public health. Although the Progressive Era incited significant social change at the beginning of the twentieth century, these reforms spread unevenly across America’s fractured social structure.

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<sup>33</sup> *Resources Associated with Segregation in Columbia, South Carolina, 1880-1960*, Nomination to the National Register of Historic Places, 21 contributing properties (Prepared for the University of South Carolina, August 2002), 4, 6.

## CHAPTER 2

### THE SOUTH CAROLINA SANATORIUM

The South Carolina Sanatorium exemplifies the promises of health reforms during the Progressive Era, as well as the shortcomings of public healthcare in a segregated society. Motivated by the national antituberculosis movement, the General Assembly of South Carolina allocated \$10,000 to fund a state sanatorium in 1914.<sup>34</sup> As the state capital, both the medical community and the legislators in Columbia influenced the development of the sanatorium as a publicly funded institution. Dr. Earnest Cooper represented the medical profession's interest and advocated heavily for the formation of a state sanatorium as well as remained influential in the development of the hospital for over two decades. A veteran of public health initiatives in Columbia, Dr. Cooper began his career at the South Carolina State Hospital, originally the S.C. Lunatic Asylum.<sup>35</sup> Founded in 1821, the South Carolina State Hospital provided a model of public healthcare for the sanatorium as well as a spatial model for a segregated, self-sufficient hospital complex. Originally, the property of the sanatorium, located seven miles outside of Columbia, was purchased with the intention of expanding black patient facilities for the South Carolina State Hospital. However, with the growing interest in the

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<sup>34</sup> South Carolina Sanatorium, *Annual Report for the Fiscal Year 1938-1939*, (Columbia, SC).

<sup>35</sup> The South Carolina State Hospital represents an early trend in South Carolina State politics to provide moderate forms of public healthcare. The asylum was the first of its kind in the lower South and the third of its kind in the country. Walter Edgar, *South Carolina: A History* (Columbia: University of South Carolina Press, 1998), 289.



antituberculosis movement and the influence of Dr. Cooper, portions of the land were reallocated in 1914 for the use of tuberculosis treatment.

As part of the broader public health movement of the Progressive Era, members of the medical profession began to work with legislative officials towards the goal of improved public healthcare. Along with Dr. Cooper, George R. Rembert, a State Representative from Richland County, led the initiative to provide state funding for a public sanatorium. Suffering from tuberculosis himself, Rembert believed the privately funded and county operated “open-air camps” that dotted the state were insufficient facilities to treat and control tuberculosis in South Carolina. After Rembert’s death in 1913, his widow, Annie Iredell Rembert, continued to work actively in the community to support the state sanatorium initiative. Women’s organizations, such as the South Carolina Federations of Women’s Clubs, provided a platform for Annie Rembert as she continued to advocate and fundraise on behalf improved tuberculosis treatment.<sup>36</sup> As seen through the creation of the South Carolina Sanatorium, antituberculosis efforts were a combination of medical, state, and community initiatives.

The sanatorium opened in 1915 with one “open-air ward of frame construction” and the capacity for sixteen white male patients. A wood-frame Administration Building, a private residence for the superintendent, and a small farm completed the complex.<sup>37</sup> Located in State Park, the property consisted of two hundred acres. By 1919, the legislature appropriated funding for the addition of a women’s pavilion for sixteen patients as well as an infirmary with the capacity for twelve male and twelve female patients. The infirmary was designed for the care of bedridden patients. Also operating as

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<sup>36</sup> “SC State Sanatorium; State Park, SC,” (Columbia: R.L. Bryan Co., 1932), SCDAH, 3.

<sup>37</sup> “Twenty Years of Achievement,” *SoCa San Piper*, May 1935, SCDAH, 1.

a communal resource the building included a kitchen and dining room with a capacity for 100 people. The fully operational farm also served the entirety of the sanatorium. It produced dozens of crops, raised chickens and pigs, and later featured a 200-ton tile silo.<sup>38</sup> The dairy, originally comprised of one cow, was another area of early expansion for the property. Some strands of tuberculosis were spread through unpasteurized milk, making the modern dairy facility an important medical feature for the sanatorium (Figure 2.2).

While the South Carolina Sanatorium was expanding, the issues of tuberculosis care for African Americans continuously sparked conversations between the hospital administration, the State Board of Health, community interest groups, and those suffering from tuberculosis. The sanatorium remained a racially segregated institution throughout its thirty-eight year history as a state operated facility. The method of segregation, however, often varied. Legally employed in the South, and to a lesser extent in the North, segregation was often implemented by differing means of racial isolation or partitioning. Examining the multiple methods of spatial segregation necessarily complicates interpretations of the Jim Crow segregation, which often focus on inequality.<sup>39</sup>

The original method of segregation at the South Carolina Sanatorium was isolation by exclusion, as no blacks were admitted from 1915 to 1919. Despite the hospital's exclusionary policies, the black community continuously requested tuberculosis treatment from the state by submitting patient applications to the South

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<sup>38</sup> The modern 200-ton silo replaced a smaller silo in 1925. South Carolina Sanatorium, *Annual Report 1924-1925*.

<sup>39</sup> Robert Weyeneth, "The Architecture of Racial Segregation: The Challenges of Preserving the Problematic Past," *The Public Historian* 27 no. 4 (Fall 2005): 11-44, 13. In this article Weyeneth distinguishes the two primary spatial strategies of segregation as isolation and partitioning. Each are the subsequently broken down into subcategories. Isolation: exclusion, duplication, temporal separation. Partitioning: fixed and malleable partitions, behavioral separation. Many of these different approaches to segregation are visible in the built environment of the South Carolina Sanatorium.

Carolina Sanatorium. Prior to the creation of the Palmetto Division, detailed in the following section, Superintendent Cooper advocated for state funded medical treatment for African-American patients at small, county operated tuberculosis camps. This was an attempt to meet the growing healthcare demands of the black community while still maintaining the exclusionary segregation of the state's sanatorium. Only four African-American men received state funded tuberculosis treatment in 1919, making Dr. Cooper's initiative a short-term solution for statewide healthcare.<sup>40</sup> When the South Carolina Sanatorium did expand to meet the healthcare needs of African Americans, the method of segregation was constantly negotiated with the hospital's growth and development of the built environment.

In addition to the racialized system of Jim Crow, the notion of segregation was also used within the contemporary medical literature of the antituberculosis movement. At least partially divorced from racial connotations, segregation in medical terminology referred to a separation between the tuberculous and the non-infected population in the context of treatment. This notion of 'medical segregation' within sanatoriums also referred to the spatial separation between patient and employee. Lastly, medical segregation applied to spatial separation between differing types of patients determined by age, gender, class, and illness.<sup>41</sup>

Several tactics of this medical segregation were employed simultaneously at the South Carolina Sanatorium. As noted previously, the sanatorium grounds were seven miles from the population center of Columbia. Architecturally, the complex was also

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<sup>40</sup> South Carolina Sanatorium, *Annual Report 1919-1920*.

<sup>41</sup> Adams, *Medicine by Design*, 26. Adams argues architecture facilitated separating patients by class in addition to medical distinctions of gender, age, and illness. Hospital designs, like the PWA building at the South Carolina Sanatorium, often featured open, semi-private, and private rooms for patients to choose from with varied prices.

designed to adhere to the guidelines of medical segregation, utilizing partitioned spaces and separate buildings for staff and differing types of patients. Also known as pavilion-plan hospitals, these multi-building sites were designed to separate the different functions of a hospital into individual buildings, or pavilions, and accommodate future additions to the site (see figure 2.1).<sup>42</sup> In 1919 the South Carolina Sanatorium built its first separate infirmary for severely ill patients, following the national trends pavilion-plan of sanatorium construction. As the sanatorium continued to grow, multiple infirmaries were built to segregate bedridden patients from those with more moderate cases of tuberculosis. Medical specialist believed segregating terminally ill patients would reduce anxiety and depression levels in patients with moderate cases of tuberculosis, enhancing their ability to recover.<sup>43</sup> Significantly, the South Carolina Sanatorium never allocated sufficient resources to maintain the recommended level of medical segregation within the hospital's African-American facilities, reducing the quality of care for African-American patients.

Also drawing from national medical trends for tuberculosis treatment, the landscape of the South Carolina Sanatorium was an essential element to healthcare at the facility. "Situated in the rolling sand hills of Richland County, overlooking undulating valleys and a panoramic spread of pine-crested ridges," the scenic location of the sanatorium ascribed to the predominant trends in tuberculosis treatment, including access to fresh air, sunshine, and environments of relaxation.<sup>44</sup> Most patients spent long portions of their days on sun porches and screened porches with views of the surrounding

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<sup>42</sup> Thomas Spees Carrington, *Tuberculosis Hospital and Sanatorium Construction* (New York: National Association for the Study and Prevention of Tuberculosis, 1911), 70.

<sup>43</sup> Carrington, *Tuberculosis Hospital and Sanatorium Construction*, 92.

<sup>44</sup> "South Carolina and Palmetto Sanatoria, State Park, South Carolina," (Columbia: South Carolina State Board of Health, ca. 1920).

landscape (Figure 2.3). Some patients were prescribed outdoor exercise and walks around the grounds. Regular requests for appropriations to improve the sanatorium's landscape were seen as attempts to improve the quality of healthcare by improving patient morale.<sup>45</sup>

As an early improvement to the landscape, the South Carolina Sanatorium installed paved walkways in 1920. These sidewalks, which included covered and uncovered segments, were praised by the administration for reducing the health risks of dust and dirt and improving the aesthetics of the grounds.<sup>46</sup> Despite these benefits, portions of the black facilities remained without sidewalks through the 1940s.<sup>47</sup> While sidewalks may seem trivial in comparison to today's standard of medical technology, seemingly simple improvements to the landscape of the sanatorium were considered important medical strategies against a disease with no cure.<sup>48</sup> As one of many examples, this disparity in the built environment demonstrates an inequality in tuberculosis treatment in South Carolina.

## 2.1 THE PALMETTO DIVISION SEGREGATION AND PUBLIC HEALTHCARE

The development and growth of the African-American facilities at the South Carolina Sanatorium highlights the relationship between government, community interest groups, and medical professionals in the Jim Crow South. Under rising pressure from community organizations and the sanatorium's staff, the legislature allocated \$10,000 to

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<sup>45</sup> *The State* (Columbia, SC), March 13, 1938. Landscape planning at sanatoriums also drew from planning and architectural movements in the Progressive Era. City Beautiful Movement, for example, sought to use architectural design and city planning to create orderly, healthy, and beautiful communities. This philosophy was used to combat tuberculosis in cities by regulating tenement housing and creating community spaces to help address issues of poverty and health. For more on the City Beautiful Movement see Daphne Spain's *How Women Saved the City*.

<sup>46</sup> South Carolina Sanatorium, *Annual Report 1919-1920*.

<sup>47</sup> South Carolina Sanatorium, *Annual Report 1919-1920*.

<sup>48</sup> Carrington, *Tuberculosis Hospital and Sanatorium Construction*, 19.

the South Carolina Sanatorium for the construction of an African-American ward in 1919. Creating greater access to tuberculosis treatment, the South Carolina Sanatorium admitted their first black patients in 1920 with the opening of the Palmetto Hall. Later known as the Palmetto Division, the eventual expansion of state funded healthcare necessitated the institution's need to spatially accommodate both medical and racial segregation.

The expansion of the South Carolina Sanatorium was a topic of great interest to both white and black communities across the state. The administration of the sanatorium believed a black division would “be of great use in preventing the spread of tuberculosis among both races.”<sup>49</sup> After all, every untreated case of tuberculosis was a threat to state population as a whole. The Richland Anti-Tuberculosis Association, later incorporated into the South Carolina Tuberculosis Association, also lobbied to increase state-funded healthcare for both races. Annie Iredell Rembert, employed at the time as the field secretary for the sanatorium, organized biracial community fundraising initiatives. Rembert worked with Rebecca Walton, an African-American laundress, to secure donations from women's organizations in the both white and black communities.<sup>50</sup> Rembert also worked with Reverend Richard Carroll, a prominent African-American community leader in Richland County. Considered an accommodationist, Carroll supported segregation so long as the state promoted equality, albeit separation, among the races.<sup>51</sup> Addressing the apparent inequality in public healthcare, Rembert spoke in support of the Palmetto Division at a race relations conference coordinated by Carroll in

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<sup>49</sup> *The State*, July 26, 1919.

<sup>50</sup> Sanatorium employee handwritten notebook, Speeches and Reports, State Park Health Center Collection, SCDAH.

<sup>51</sup> *Resources Associated with Segregation in Columbia, South Carolina, 1880-1960*, 9.

1918.<sup>52</sup> Through churches, women’s clubs, and various other community organizations of both races, the statewide community raised the necessary \$7,000 to augment the limited legislative appropriations for the construction of Palmetto Hall.<sup>53</sup>

The original Palmetto Hall was a wood-frame cottage with open interior wards for ten males and ten females and screen porches. Planned to be partially self-sufficient, Palmetto Hall also featured a dining room, pantry, kitchen, as well as living quarters for black nurses.<sup>54</sup> With an addition in 1921, three beds were added per sex in an isolated wing of the cottage for advanced cases of tuberculosis.<sup>55</sup> The segregation of races was accomplished on site by separate buildings. As the “the Palmetto division [was] on the extreme point of the horseshoe,” spatial planning was a tactical strategy of the sanatorium’s administration to secure segregated facilities (see figure 2.1).<sup>56</sup> With the expansion of the complex over the next two decades, the sanatorium’s management continued to use terrain and landscape as planned spatial divisions to support racial segregation on the property. Serving as one example, sidewalks did not directly connect the white and black facilities for over twenty years.<sup>57</sup>

The pavilion-plan design of the South Carolina Sanatorium accommodated growth, such as the expansion of African-American facilities, with the addition of new buildings. Built over several decades, each building’s design varied. Some buildings offered more personal privacy like individual lockers; others offered more comfortable social spaces like communal living rooms. Despite the eclectic composition of building

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<sup>52</sup> *The State*, March 18, 1918.

<sup>53</sup> A sanatorium employee handwritten notebook indicates \$13,000 was raised by the black community. All other records consulted list the figure closer to \$7,000. Sanatorium employee handwritten notebook, Speeches and Reports, State Park Health Center Collection, SCDAH.

<sup>54</sup> South Carolina Sanatorium, *Annual Report 1919-1920*.

<sup>55</sup> South Carolina Sanatorium, *Annual Report 1919-1920*.

<sup>56</sup> South Carolina Sanatorium, *Annual Report 1919-1920*.

styles, one consistency remained throughout the sanatorium: racial inequality was apparent. This is not a profound realization for the history of American race relations. However, the built environment of segregation has only recently been used to explore the lived experience of the Jim Crow era.<sup>58</sup> Furthermore, the architectural disparity between segregated buildings gains a new significance in relation to the history of disease.

During the development of the South Carolina Sanatorium, structural decisions were more than aesthetic choices; they were essential to the treatment of tuberculosis patients.<sup>59</sup> Before surgical alternatives became more widely used at the sanatorium in the 1930s, sunlight and fresh air remained the recommended treatment for patients. The sanatorium purposefully incorporated sun porches and large windows into their architectural designs in adherence to contemporary medical advice. Significantly, the pavilions designated for black patients were not afforded the same architectural amenities as white facilities. Featuring sash windows, white pavilions were designed to promote ample airflow for patients (Figure 2.4). Presumably to reduce construction costs, the Palmetto Hall was built with substantially smaller awning windows. The hinged design of awning windows supplied substantially less airflow (Figure 2.5). By the standards of the time, the quality of healthcare was diminished for African-American patients. Through the architecture and built environment of the South Carolina Sanatorium, the inequality of the antituberculosis movement in the segregated South took visible form.

Throughout the 1920s and 1930s the Palmetto Division of the South Carolina Sanatorium expanded its attempts to meet the needs of the state's African-American population. Lengthy patient waitlists, particularly for the Palmetto Division, remained a

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<sup>58</sup> Weyeneth, "The Architecture of Racial Segregation," 11.

<sup>59</sup> Adams, *Medicine by Design*, 913.



constant concern for the administration during these early decades.<sup>60</sup> With state funding largely limited to operational costs, the South Carolina Sanatorium often depended on community donations to expand the hospital's facilities. Considering the racial wealth disparity in South Carolina, this reliance on private donations caused great inconsistency in the quality of healthcare provided to the state's tuberculous. Fundraising for the Palmetto Division gained some national attention, drawing donations from famed African-American entrepreneur Madam C. J. Walker; however, statewide donations could never meet the needs of the hospital.<sup>61</sup> So while the white division had funding to incorporate newly constructed buildings, the Palmetto Division relied on temporary structures and repurposed buildings.

## 2.2 CAMPBELL HALL ADVANCING HEALTHCARE AND WOMEN ACTIVISTS

As a continuation of gender roles in the Progressive Era, the women of the state were particularly active in advocating for the addition of a children's ward at the South Carolina Sanatorium. Additionally, medical advances in the 1920s shaped the design the new facility for children. In 1927, the institution opened Campbell Hall, a children's ward for white patients (Figure 2.6). There was no equivalent facility for black children in the state. Instead the South Carolina Sanatorium and SC Tuberculosis Association jointly funded mobile clinics operated by the sanatorium's staff and targeted impoverished communities around the state, a large percentage of which were African American.<sup>62</sup> These outreach initiatives were significant public healthcare programs. Nonetheless, the

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<sup>60</sup> South Carolina Sanatorium, *Annual Report 1929-1930*.

<sup>61</sup> *Southern Indicator* (Columbia, SC), June 13, 1914.

<sup>62</sup> South Carolina Sanatorium, *Annual Report 1939-1940 and 1940-1941*, 30.

addition of Campbell Hall highlighted racial segregation as a limiting factor to the quality of public healthcare provided to African-American children in the South Carolina.

Campbell Hall offered white children the most medically advanced tuberculosis treatment facility in the state. The legislature appropriated \$25,000 for the project and architect Arthur B. Hamby was hired for the design.<sup>63</sup> Selecting a hill on the western corner of the property, the two-story building featured good views of the surrounding countryside with sun porches and decks on both floors.<sup>64</sup> While these design features prescribed to the standard treatment of tuberculosis in the early-twentieth century, the tile and terrazzo used in Campbell Hall relied on modern notions of hospital design and sanitation.<sup>65</sup> A complete hospital within itself, the building included patient wards, operating and consultation rooms, a dining room, doctors and nurses' quarters, a playroom, and a schoolroom.

Like many of the building campaigns at the sanatorium, Campbell Hall highlights the significant relationship between the state government and charitable organizations. The South Carolina Federation of Women's Clubs and the South Carolina Council of Farm Women lobbied the legislature to fund a children's ward. After securing government funds, women's clubs organized statewide fundraising campaigns to provide furnishings for the building.<sup>66</sup> Despite government's increasing involvement in healthcare during the Progressive Era, public healthcare services still relied on the private and charitable sector to ensure fiscal livelihood.

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<sup>63</sup> "Children's Unit South Carolina Sanatorium," *The State*, August 2, 1925; "Members of Building Committee Agree Upon Site at Meeting Here," *The State*, May 16, 1925.

<sup>64</sup> "Children's Unit South Carolina Sanatorium," *The State*, September 02, 1925.

<sup>65</sup> Annmarie Adams, *Medicine by Design*, 115.

<sup>66</sup> "Twenty Years of Achievement," *SoCa San Piper*, May 1935, 5.

This partnership between government supported healthcare and charitable organizations secured a leadership role for white women and the development of South Carolina Sanatorium. The Federation of Women’s Clubs women were thanked for their efforts in an inscription on the cornerstone of Campbell Hall. The Richland County Federation branch was the “hostess” during the dedication of the corner stone, providing beverages and snacks for the occasion.<sup>67</sup> This dual role of active government lobbyist and party hostess highlights women’s position as municipal housekeepers – extending women’s domestic responsibility into the public sector and shaping the landscape of public healthcare.<sup>68</sup> Campbell Hall serves as an example of how women were acknowledged for their efforts in community organization for the South Carolina Sanatorium. In other sanatorium building campaigns, however, black women were never formally acknowledged for their fundraising efforts by the institution.

### 2.3 STAFF HOUSING EMPLOYEES AND THE BUILT ENVIRONMENT

On-site staff housing at the South Carolina Sanatorium shaped the social structure of authority at the institution by creating separate and distinct spaces for doctors, nurses, and support staff. Employee housing also provided separation between staff and patients, as well as separation among the races. Echoing the built environment of patient facilities, employee housing both reflected and reinforced these differing modes of medical and racial segregation. The isolation of the South Carolina Sanatorium necessitated on-site housing for medical and support staff. Shown by a constant request for funding, the

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<sup>67</sup> “Clubwomen’s Interest and Activities,” *The State*, November 16, 1925.

<sup>68</sup> Adams, *Medicine by Design*, 9.

administration believed providing staff housing was essential to the functionality of a hospital intentionally designed to be isolated.

Beginning with the highest-ranking staff, the original design for the sanatorium included a superintendent's house for Dr. Cooper. Completed in 1915, the one-story brick bungalow flanked by two side porches provided a domestic space for the superintendent and his family (Figure 2.7).<sup>69</sup> By 1947, four freestanding doctors' houses had been built. Additionally, the top floor of the Administration Building was repurposed into a single-family apartment for medical staff. When asking for appropriations, the sanatorium staff argued separation between patients and staff was necessary for the safety of staff families.<sup>70</sup> In fact, Dr. Rudolph Farmer's wife did become infected with tuberculosis during her husband's tenure at the facility in the 1930s. The legislature approved funding for a personal nurse for Mrs. Farmer.<sup>71</sup> Separation between patients and staff remained an important factor even when treating staff family members for tuberculosis. Indeed, spatial separation between staff and patients was also a means creating and maintaining authority.

Although no black doctors were employed during this time period, nurses of both races staffed the sanatorium. Nurses were not afforded the same level of privacy as doctors and their families, but their housing was still an important contributing factor to the landscape of the South Carolina Sanatorium. In accordance with hospital trends in the early twentieth century, the spaces afforded to nurses at the sanatorium served dual functions. They served as domestic spaces to reflect women's traditional role as caregivers, while simultaneously reflecting women's emerging role as medical

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<sup>69</sup> "Twenty Years of Achievement," *SoCa San Piper*, May 1935, 5.

<sup>70</sup> South Carolina Sanatorium, *Annual Report 1926-1927*.

<sup>71</sup> South Carolina Sanatorium, *Annual Report 1933-1934*.

professionals.<sup>72</sup> During the early years of the institution, personal spaces for nurses were planned into white and black patient buildings. The Administration Building also provided housing for white nurses. By the 1930s, the existing structures could not sufficiently accommodate the growing number of nurses. After closing the building to patients, one “poorly adapted” white women’s infirmary housed three nurses per room and one nurse in a hallway.<sup>73</sup>

After several years of lobbying from the sanatorium staff the legislature appropriated \$10,000 dollars to address the housing issue, opening a new separate white nurse’s residence in 1931 (Figure 2.8). The two-story house with weatherboard siding featured private and semi-private bedrooms with communal living spaces. A large open-air porch supported by columns surrounded the building on three sides, completing the structure’s domestic feel. Without family residences or guaranteed private rooms, the nursing positions at the South Carolina Sanatorium often attracted student nurses and recent graduates of the Columbia area nursing schools. Many left the sanatorium after getting married, while some made the South Carolina Sanatorium their permanent home. Disproportionally affected by the struggle for personal space, African-American nurses were denied separate housing and continued to live in small spaces within patient wards into the 1940s.<sup>74</sup>

Housing played an important part in the relationship between the different classes of staff and the operation of the sanatorium. The South Carolina Sanatorium hired mostly African-American workers for support staff positions. Staff members, referred to as “servants”, included farm workers, dairy operators, cooks, kitchen hands and general

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<sup>72</sup> Adams, *Medicine by Design*, 71.

<sup>73</sup> South Carolina Sanatorium, *Annual Report 1930-1931*.

<sup>74</sup> “Four Decades at S.C. Sanatorium,” *The State*, July 28, 1963.

maintenance workers. Accommodations were initially very bleak. When Bill Adams arrived as the first servant employee in 1915, he slept on a wooden pallet in an abandoned structure because no accommodations had been made.<sup>75</sup> As accommodations improved, support staff lived in simple wooden structures accompanied by outhouses. The administration regularly requested appropriations from the state legislatures to address the quality and quantity of housing for support staff. Dr. Cooper insisted housing would address the issue of discipline, as “labor can be controlled more easily when houses are supplied.”<sup>76</sup> Considering the racial demographics of the workers, this shows Dr. Cooper intended to use the built environment to address discipline amongst the African-American staff. In 1927, three four-room houses were constructed for \$500.00 each and scrap material was utilized from a patient building construction project.

Unlike the doctors and nurse’s quarters, support staff housing was not incorporated into the aesthetic design of the sanatorium. Many of the support staff houses featured unpainted wooden siding and galvanized roofing, differing from the cottage aesthetic of the other buildings prior to the late 1930s. This visual disparity between the classes of employee highlighted the limited provisions the support staff received from the institution (Figure 2.9). The sanatorium’s annual reports never included detailed accounts of servant quarters or an official count of servant houses.<sup>77</sup> Even so, housing remained a constant concern of the administration. By 1931, two thirds of support staff lived on sanatorium property; yet, labor remained transient, seasonal, and short-term.<sup>78</sup> Improving

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<sup>75</sup> “Twenty Years of Achievement,” *SoCa San Piper*, May 1935, 7.

<sup>76</sup> South Carolina Sanatorium, *Annual Report 1919-1920*, 70. The specific details of this “discipline” issue are not recorded in the *Annual Report*. Even so, worker disciplinary issues are mentioned in several years of the *Annual Reports*, as well as the State Board of Health meeting minutes.

<sup>77</sup> South Carolina Sanatorium, *Annual Report 1927-1928*.

<sup>78</sup> South Carolina Sanatorium, *Annual Report 1930-1931*.

the sanatorium's infrastructure was seen as a means to improve employee retention and alleviate discipline issues with workers, particularly among the primarily African-American support staff.

#### 2.4 EARNEST COOPER COMMUNITY BUILDING PATIENTS AND THE BUILT ENVIRONMENT

As seen through the examples of the Palmetto Division and Campbell Hall, the sanatorium's administration and community interest groups initiated many of the hospital's building projects. Additionally, patients at the sanatorium also helped to shape the growth and expansion of the facilities. The long campaign to build the Earnest Cooper Community Building demonstrates the influence of patients in the development of the South Carolina Sanatorium (Figure 2.10). The unique amenities of the Cooper Building also illustrate patients' ability to shape the built environment of the institution. Intended to be the center of the sanatorium community, the design of the Cooper Building also raises some important questions about segregation at the South Carolina Sanatorium.

In 1924, patient Alice Ray Frierson began a campaign to build a chapel and community center at the sanatorium.<sup>79</sup> Known as the "Sunshine Girls," Frierson and eleven other women fundraised for ten years (Figure 2.11). They placed adds in state and local newspapers, including the sanatorium's patient-operated newsletter, the *SoCaSan Piper*.<sup>80</sup> Most of the donations came from patients and former patients as well as their families. Named in honor of longtime superintendent, the Earnest Cooper Community

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<sup>79</sup> *The State*, April 12, 1925.

<sup>80</sup> "Twenty Years of Achievement," *SoCa San Piper*, May 1935, 3.

Building finally opened in 1935. Serving many functions, the building included a library, auditorium, and U.S. Postal Office. The Cooper Building also featured a small store, a barbershop, and two guest-rooms to accommodate patient's visitors.<sup>81</sup> All of these amenities were suggestions from patients and former patients involved with the fundraising campaign.

A popular element of the Cooper Building, the auditorium hosted regular Sunday church services, weekly "picture" or movie nights, and performances from community groups.<sup>82</sup> Despite the attention to detail in regards to other buildings, the official records of the institution do not address segregation within the Cooper Building. By examining the material record, we can ascertain information about segregation on the property. Architecturally, the auditorium was not designed to impose spatial segregation. The 300 seats were laid out in a single-story space. A narrow aisle on either side separated the center and side seating sections. However, visually the space remained quite open (Figure 2.12). To negotiate segregation within an open space the facility may have completely excluded black patients or temporally restricted use of the building by race. Expected social behavior, such as racially defined seating areas, could have also been used as a strategy to segregate the space. At the very least, the physical location of the Cooper Building was more accessible to white patients, as black medical wards were on the periphery of the property (see figure 2.1). Moreover, designated sidewalks connected

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<sup>81</sup> Prior to the implantation of chemotherapy in the 1940s, an average stay at a sanatorium was eighteen months. Physicians noted these long hospitalization periods could cause depression and negatively influences recovery rates. Leading hospital planners suggested including "amusement pavilions" or community centers, like the Cooper Building, to provide patients with activities and help combat depression. Carrington, *Tuberculosis Hospital and Sanatorium Construction*, 42.

<sup>82</sup> "Twenty Years of Achievement," *SoCa San Piper*, May 1935, 5.



white wards to the Cooper Building, which was an important design element for ailing patients.

## 2.5 PWA BUILDING MODERN MEDICINE AND FEDERAL ASSISTANCE

The New Deal reinforced segregation at the South Carolina Sanatorium through the development of the PWA Building in 1938 (Figure 2.13). By the 1930s it was evident the South Carolina Sanatorium needed new facilities to accommodate medical advances in tuberculosis treatment, including surgical treatments such as Pneumothorax, or lung collapse therapy. Pressure was also mounting from antituberculosis advocates to address the apparent need to improve African-American tuberculosis treatment in the state. Isabel R. Cain served as the sanatorium's Field Secretary in the 1920s and 1930s. Reporting directly to the State Board of Health, Cain articulated the need for better African-American facilities frequently and adamantly throughout her tenure. The South Carolina Tuberculosis Association also actively lobbied the legislature to secure more treatment facilities for African Americans (Figure 2.15). In the midst of the Great Depression state funding for either of these improvements was improbable, as were the private charitable donations the sanatorium had become so reliant upon. By 1936, however, the South Carolina Sanatorium was able to secure federal funding for a modern hospital building through the New Deal's Public Works Administration (PWA) (Figure 2.14).<sup>83</sup>

The PWA Building opened in 1938 with room for 250 patients, doubling the sanatorium's capacity. The six-story brick building had a variety of patient wards with varying degrees of privacy. The building featured modern office space for doctors and

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<sup>83</sup> The National Archives College Park, MD holds the archival records for the Public Works Administration. Along with many others of the PWA projects, the records for the South Carolina Sanatorium project are listed as destroyed (2013).

nurses, a receiving lounge for guests, and a large cafeteria.<sup>84</sup> The architectural design of the building incorporated both traditional and modern medical technologies for treating tuberculosis. Sun porches were incorporated into every patient floor and an extensive surgical department designed for the sixth floor. The expansive U-shaped PWA Building became the focal point of the hospital grounds and was considered a crowning accomplishment for public healthcare in South Carolina (Figure 2.16). However, the PWA project also highlighted the underrepresentation of African-American patients at the South Carolina Sanatorium.

At the opening of the PWA Building in 1938 a total of 440 beds were available throughout the sanatorium, yet only 135 beds were accessible to African Americans.<sup>85</sup> The disparity did not go unnoticed. This set in motion a restructuring of spatial race relations at the institution. At the end of the fiscal year in 1939 the Executive Committee abolished the Committee on Admissions, which “empowered the Superintendent to act and be held responsible for the admission of all patients at the Sanatorium.”<sup>86</sup> This administrative decision led to a drastic increase the number of black patients receiving treatment (Figure 2.17). Even so, the spatial relationship between patient facilities remained the same. Black and white patients did not occupy the same wards. White patients were afforded treatment at the newly constructed PWA facility, while black patients occupied formerly white spaces.

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<sup>84</sup> South Carolina Sanatorium, *Annual Report 1939-1940 and 1940-1941*.

<sup>85</sup> South Carolina Sanatorium, *Annual Report 1939-1940 and 1940-1941*, 11.

<sup>86</sup> South Carolina Sanatorium, *Annual Report 1939-1940 and 1940-1941*, 10.

From this point forward, the sanatorium established a roughly equal racial admissions rate.<sup>87</sup> Just as the national antituberculosis movement was motivated by socioeconomic, political, and humanitarian factors, the incentives for providing better healthcare for African Americans at the South Carolina Sanatorium were also multifaceted. Providing insight into the economic and social implications of the sanatorium's new admission policy, a board member described the situation in 1940 as such:

Last year nearly 700 Negroes died of tuberculosis in our state... This is an appalling figure when thought of in terms of people who are preparing our meals, nursing our children and performing other domestic duties in homes, it is alarming. It would not be fair to you to our negro friends if I did not repeat with emphasis that apt saying of my colleagues, "The palace on the hill cannot be safe as long as there is disease in the hovel below."<sup>88</sup>

Emphasizing hierarchy, this speech links race and healthcare to public interests. The humanitarian effort of the sanatorium to provide better healthcare for African Americans was genuine and meaningful. However, the complex motivations behind these efforts must be contextualized within the social order of the segregated South.

Demonstrating the intent to better serve the black community, the Executive Committee declared juvenile cases of tuberculosis would no longer be treated at the sanatorium after 1940. The former children's ward, Campbell Hall, was designated a "ward for Negro women."<sup>89</sup> By 1942 the sanatorium reached the height of its patient capacity under state control, providing 550 total patients beds: 328 for whites and 222 for blacks.<sup>90</sup> Although the desire to strengthen available tuberculous treatment for African Americans grew within the administration at the onset of the 1940s, racial segregation also remained a primary goal.

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<sup>87</sup> Compilation from South Carolina Sanatorium, *Annual Reports 1950-1969*.

<sup>88</sup> Employee Speech c. 1940, Speeches and Reports, State Park Health Center Collection, SCDAH.

<sup>89</sup> South Carolina Sanatorium, *Annual Report 1940-1941 and 1941-1942*, 7.

<sup>90</sup> South Carolina Sanatorium, *Annual Report 1939-1940 and 1940-41*.

## 2.6 NEGRO WOMEN'S WARD: PRIVITIZATION AND SEGREGATION

A product of both medical and social changes in the 1950s, the Negro Women's Ward ushered in the era of privatized tuberculosis treatment with an architectural style novel to the South Carolina Sanatorium. In the 1940s scientists at Rutgers University developed an antibiotic treatment for tuberculosis. This significant medical advancement changed the treatment regime of patients at the sanatorium, as well as the way the institution utilized its facilities. The 1950s also brought new social and political challenges to the sanatorium's policies of public healthcare and segregation. As a state institution, the sanatorium was influenced by the growing public dissatisfaction with Jim Crow legislation. In 1951, the case *Briggs v. Elliot* legally challenged segregation in South Carolina. It was the first case to do so in the South since the end of Reconstruction. The Charleston federal district court upheld South Carolina's right to segregation. After this defeat, *Briggs v. Elliot* became one of the five court cases heard by the Supreme Court in *Brown v. Board of Education* in 1954.<sup>91</sup> Even before *Brown v. Board of Education*'s historic defeat of *de jure* segregation, the atmosphere of South Carolina's capitol city had changed. Allen University, a historically black college in Columbia, held a conference in 1952 demanding integration in South Carolina.<sup>92</sup> The state was under increasing stress to address the issues of segregation.

In response to the mounting political and social pressures of the 1950s, the South Carolina state legislature allocated \$124 million to improve the school system in

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<sup>91</sup> Edgar, *South Carolina*, 522.

<sup>92</sup> *Resources Associated with Segregation in Columbia, South Carolina, 1880-1960*, 10.

accordance the principles of “separate but equal.”<sup>93</sup> Public healthcare also received funding in the early 1950s as a means to preemptively address legal challenges to segregation. In 1954 the state legislature appropriated just over \$2 million for “permanent improvements” at many state institutions, including the State Hospital, State Penitentiary, and South Carolina Sanatorium. These funds were intended to last state institutions for the foreseeable future, greatly reducing the role of state government in many aspects of social welfare. The South Carolina Sanatorium received \$500,000 from the state legislature to build a new ward for African-American women.<sup>94</sup> Additionally, the state legislature voted to give the sanatorium’s board of trustee’s complete control of institution. By 1954, the South Carolina Sanatorium was no longer a public healthcare institution. The new Negro Women’s Ward was the last manifestation of state sponsored healthcare at the facility.

In addition to responding to the social and political issues of the 1950s, the Negro Women’s Ward also accommodated modern medical advances in tuberculosis treatment. Prominent Columbia architects, Lafaye, Fair, Lafaye, built a single-story brick structure with the 27,000 square feet that included patient rooms, surgical facilities, and a kitchen. Significantly, the Negro Women’s Ward was the first patient structure at the sanatorium built without porches (Figure 2.18).<sup>95</sup> By the early 1950s, the medical recommendation of sunshine and fresh air was replaced by a regiment of antibiotics.<sup>96</sup> Nearly seventy years after Robert Koch’s discovery of the tubercle bacillus, a cure for tuberculosis was finally

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<sup>93</sup> Edgar, *South Carolina*, 522.

<sup>94</sup> “Permanent Improvements Voted for Many State Institutions,” *The State* (Columbia, SC), March 31, 1954.

<sup>95</sup> “106-Bed Unit Will Nearly Double State Park’s Accommodations For Negro Women TB Patients,” *The State*, September 18, 1954.

<sup>96</sup> Ott, *Fevered Lives*, 7.

found. With more emphasis on interior spaces than exterior features, medical advances in tuberculosis treatment were legible in the built environment of the South Carolina Sanatorium and the modern design of the Negro Women's Ward.

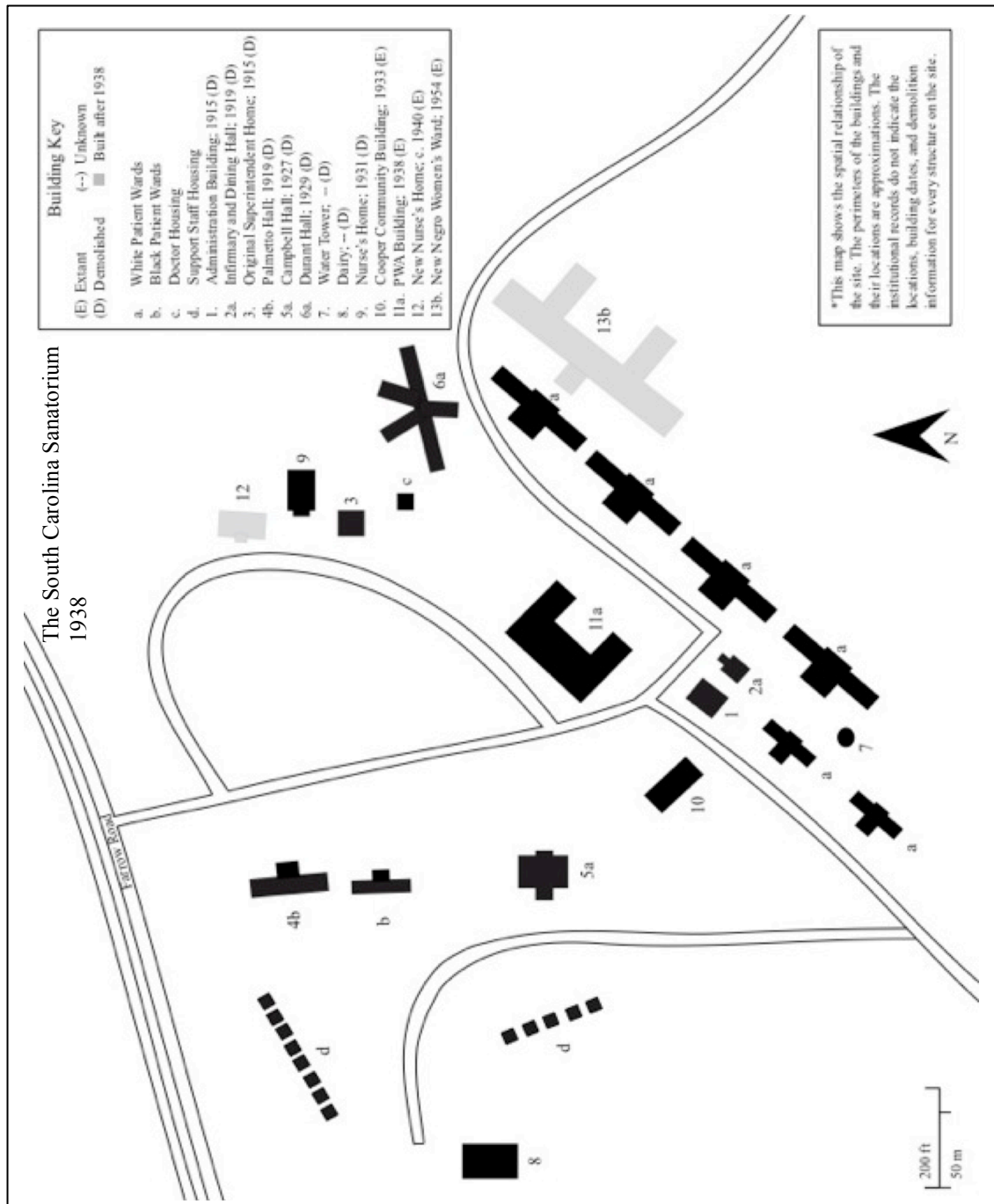


Figure 2. This map indicates the use of spatial segregation at the sanatorium. A combination of aerial photographs in the 1930s and 1940s, building photographs, and text descriptions of the site were used to create this map. After the addition of the PWA Building (11a), white patients were exclusively treated in this singular modern facility. This changed the segregation of facilities at the site. Formerly white patient wards (a) transitioned into spaces for black patients after 1938.

## Farm at the South Carolina Sanatorium



Figure 2.2 By 1930 the sanatorium's dairy featured sterilization equipment, an aerator, a bottler, and a refrigerator. That year the dairy produced over 30,000 gallons of milk. The development of a modern dairy demonstrated the institution's adherence to contemporary standards in the treatment of tuberculosis. A strand of tuberculosis could be spread through unpasteurized milk; therefore, the dairy was seen as an important part of the landscape of the sanatorium.



## Patient Pavilion

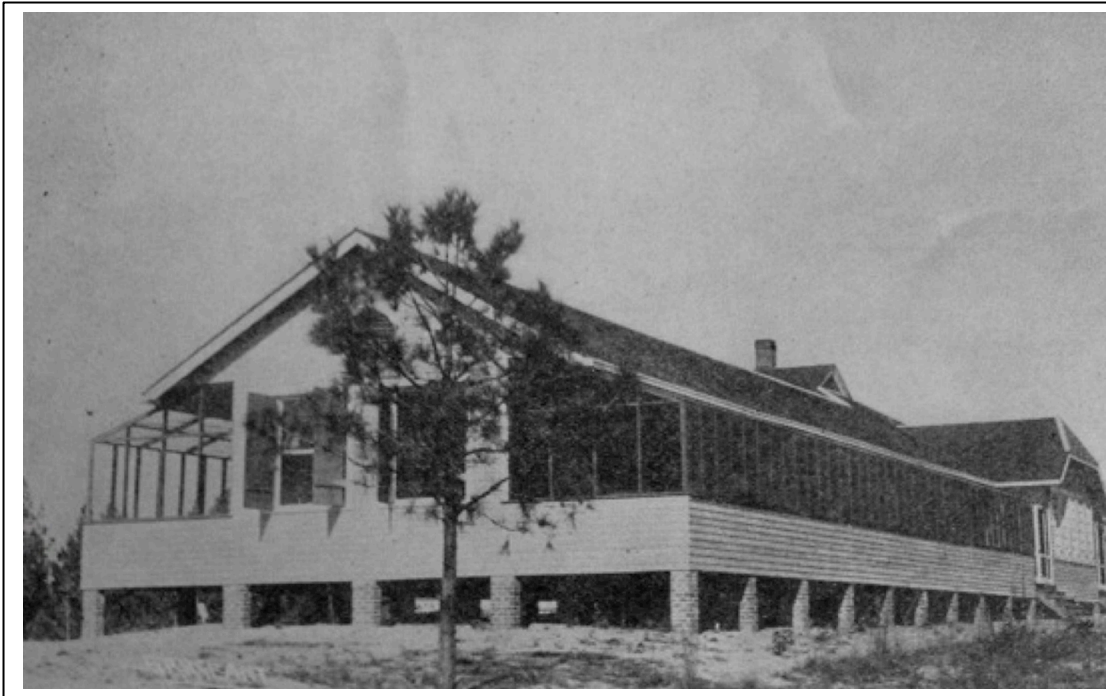


Figure 2.3 This building, and others like it, was a significant piece of medical technology used to treat patients at the South Carolina Sanatorium. Note the screen porches on the front and back of the building. Clearly visible on the back porch, the gabled roof of the structure does not fully extend over the porches. This versatile design provided patients with both access to sun as well as shelter when needed. The porches and the large sash windows indicate the building was designed for maximum air circulation, which adhered to the contemporary medical standards of tuberculosis treatment in the 1920s.

## Porch View of a White Women's Ward



Figure 2.4 The sanatorium used architectural elements to aid tuberculosis treatment. This photograph shows the interior view of one of the screen porches in a women's infirmary ward. Note the large sash windows behind the patient beds. Both of these features gave white patients plenty of access to fresh air.

## Interior View of Black Men's Ward



Figure 2.5 The funding provided by the state was not sufficient to construct black facilities to the same standards as white facilities. As seen in Palmetto Hall pictured above, the awning windows above the patient beds supplied limited airflow. Also note the unpainted walls. It was several years before Palmetto Hall was painted.

## Campbell Hall

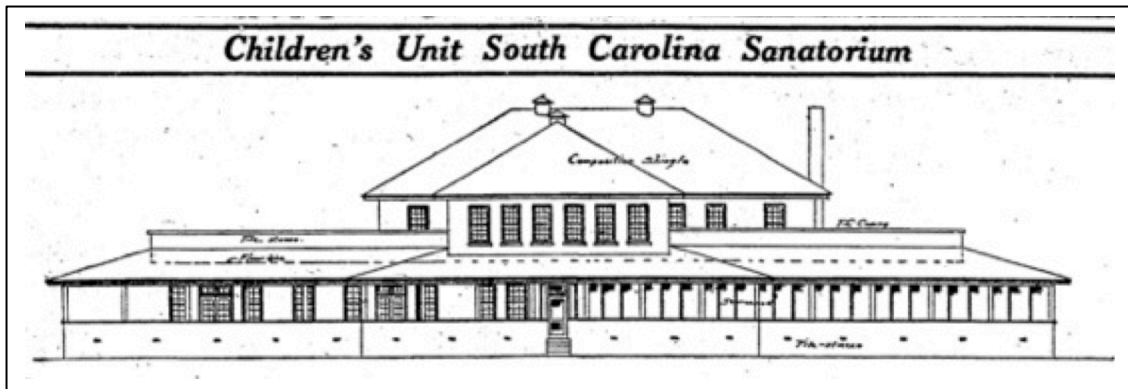


Figure 2.6 The front elevation of the Campbell Hall shows several architectural elements used for the treatment of tuberculosis. The first floor features screened sleeping porches, which provided sheltered access to fresh air. The second floor features two sun porches on either side of the central second-story. Exposure to sunlight was thought to help kill contagious germs and aid remission.

## Superintendent's House



Figure 2.7 Built in 1915, the Superintendent's House was the only building at the sanatorium constructed from brick until the addition of another doctor's bungalow in 1927. The first brick building for patient treatment was built in 1938. More expensive than wooden structures, the medical staff houses were intended to be permanent residential homes. Superintendent Copper lived here with his family for twenty years.

## Nurse's House



Figure 2.8 Built in 1931, this was the first separate structure for the residential nurse staff at the sanatorium. Black nurses were only afforded living spaces inside of patient buildings, which provided considerably less privacy. When a new brick building was built for the white nurses in the 1940s, black nurses moved into this building.

## Employee Housing, Condemned Building



Figure 2.9 This former employee house was in a state of extreme disrepair in the 1970s. Many wooden structures on the site were torn down under orders of the new administration in the 1950s as a means of fire prevention. Today, few remnants of the support-staff infrastructure still remain on the site. Without the material record, many details of the worker experience at the sanatorium are difficult to ascertain.

## Cooper Community Building



Figure 2.10 Note the ramp on the side of the Cooper Community Building. The ramp provided access to the second-story auditorium for patients too ill to use the interior stairs. Patients at the sanatorium conceived the idea for a community building and fundraised for ten years in order to make their vision a reality. Patients' needs, such as ramp access, are seen in the architectural design of the building.



## Ceremony at Cooper Community Building



Figure 2.11 Patients contributed to the development of the sanatorium. Here, two women sit at the construction site of the Earnest Cooper Community Building in 1933. The pillows, blanket, and reclining chair, indicate the woman on the right is most likely a patient. Patients, and women in particular, played an essential role in funding and helping to design the Cooper Community Building.

## Interior View of Cooper Auditorium



Figure 2.12 With seating for 300, the interior of the Cooper Building auditorium could accommodate nearly twice the patient population of the sanatorium (including both races) when it was built in 1933. With no architectural features dividing the space, segregation was not enforced with spatial patricians. Rather, segregation of the space most likely relied on exclusionary tactics or social norms of seating patterns.

## Aerial View of Sanatorium, 1938

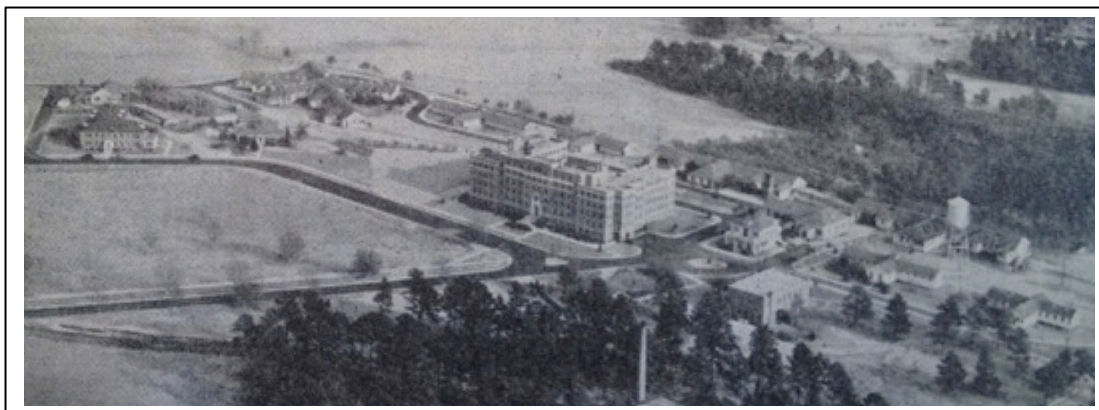


Figure 2.13 This aerial view shows the South Carolina Sanatorium in the early 1940s. Significantly, several structures are missing from this photograph, including all African-American patient and employee buildings as well as service structures, like the barn and dairy. This absence of black facilities demonstrates the spatiality of racial segregation utilized at the site. Additionally, the spatial separation of patients from service structures, which were considered loud, dirty, and disruptive to treatment, represents the use of medical segregation on the site.

## Front of PWA Building



Figure 2.14 The PWA building was the first patient structure at the sanatorium built from brick. Fire hazard was a common concern of the administration, especially after a fire took place in a patient pavilion in 1932. Brick buildings were seen as improvements to the healthcare provided at the hospital. White patients were treated here after the completion of the PWA building, while black patients were segregated to the older, wooden structures on the property until the 1950s.

## Ceremony at PWA Building



Figure 2.15 Members of the Freemasons held a ceremony at the Public Works Administration's construction site in 1938. Like many community organizations in South Carolina, the Freemasons often advocated on behalf of the sanatorium, provided funding for buildings, and participated in antituberculosis outreach programs. The socioeconomic restrictions of Jim Crow hindered equal participation from African-American organizations in the development of the sanatorium.

## Back of PWA Building



Figure 2.16 Opening in 1938, the PWA Building was reported to be the most medically advanced sanatoriums in the South. The surgical department on the sixth floor included modern medical advances like specialized overhead lighting and separate sterilization rooms. Maintaining some architectural elements of traditional sanatorium buildings, both wings had large sunrooms at the end of each patient floor. This building was used exclusively for white patients expect for the surgical facilities. A surgical ward was added to the Palmetto Division for African-Americans in that 1940s in order to reestablish a strict segregation of facilities.

## Chart of Patient Admissions Percentages

<b>Percent of Patients Admitted Based On Number of Applications Received 1939</b>	
White Male	67%
White Female	89%
Black Male	50%
Black Female	28%

<b>Percent of Patients Admitted Based On Number of Applications Received 1940</b>	
White Male	87%
White Female	76%
Black Male	96%
Black Female	96%

Figure 2.17 This chart shows the change in acceptance rates after the administrative policies shifted in 1940 in response from the growing pressure to address the disparity in healthcare among the races. The percentage of white women admitted to the institution decreased in order to accommodate more African-American patients. The substantial increase in African-American patients forced spatial changes at the institution. All white patients were treated in the newly built PWA building, while all African Americans were treated in the older, less medically advanced buildings.

## New Negro Women's Ward



Figure 2.18 This low brick structure was built in 1954. The roof was reinforced to accommodate an additional floor if the sanatorium wanted to expand the facility. Unlike previous patient wards, this structure has no porches or sundecks. Antibiotics became widely used for tuberculosis treatment in the 1950s, reducing the medical need for these architectural elements.



## CONCLUSION

Throughout the American sanatorium movement many states created government-funded institutions for the treatment of tuberculosis. While an increasing amount has been written on the experience of tuberculosis at such institutions, few works examine the influence of segregation in this segment of public healthcare. The site of the South Carolina State Sanatorium provides a lens into the social and political negotiations between race, medical treatment, and the built environment. Advocating for improved tuberculosis healthcare, a dynamic combination of politicians, medical professionals, and community interest groups shaped the development of the sanatorium. Patients also actively influenced the quality of healthcare provided at the sanatorium through building campaigns. Every advocate worked towards the betterment of those suffering from tuberculosis. However, the quest for improved tuberculosis treatment was constantly weighed against the dogmatic support of state-sponsored segregation. The landscape of the South Carolina Sanatorium demonstrates how segregation in the South facilitated an unequal system of tuberculosis treatment and public healthcare.

The built environment of the South Carolina Sanatorium continued to change and adjust to new social, political, and medical factors throughout the second half of the twentieth century. Additionally, African Americans became the primary demographic admitted into the institution. Throughout the hospital's thirty-eight years as a public institution, the racial composition of patients heavily favored white South Carolinians.

The shifting demographics post-privatization was, in part, the institution's attempt to reinforce segregation by supporting the policies of "separate but equal." The advent of antibiotics also greatly changed the demographics of disease in the 1950s. Post-war affluence afforded many white South Carolinians access to improved healthcare, such as early tuberculosis screening and antibiotics. South Carolina's black population, however, remained largely rural, impoverished, and at greater risk for tuberculosis. By the late 1970s, advances in medicine sufficiently suppressed the tuberculosis death rate in South Carolina for both races. Without the state's need for a tuberculosis treatment facility, the property transitioned into a corrections facility for women in 1984.

Portions of the site are still standing, left vacant since the departure of the Department of Corrections in 2002.<sup>97</sup> Some buildings remain in use as offices for the South Carolina Department of Health and Environmental Control. Significantly, in 2007 the South Carolina Budget and Control Board deemed several structures on the site as safety hazards of no economic value. The state sanctioned the demolition of twenty-four structures.<sup>98</sup> Many of the buildings were dilapidated remnants of the African-American facilities, erasing the history of segregation from the landscape. Much of what was lost in 2007 relates to the community that was created by the sanatorium, which was unique to

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<sup>97</sup> SHPO Case Files, South Carolina Sanatorium and State Park Medical Center. The property was used as a corrections facility for women from 1984 to 2002. Many of the buildings built for the treatment of TB were used as part of the jail complex.

<sup>98</sup> State Historic Preservation Office Case Files, South Carolina Sanatorium and State Park Medical Center, SCDAH. The buildings demolished were not all individually specified by age. It is presumable that some demolished in 2007 were built after the scope of this thesis. The State Historic Preservation Office (SHPO) requested the reconsideration of the City's demolition decision on behalf of the historical significance of this site. This request was denied, but the demolition order was delayed to allow for documentation of the structures before their demolition. With limited resources, SHPO offices across the country are increasingly forced to take retroactive rather than proactive measures.

this site as a rural hospital built during the Jim Crow era. With the loss of these twenty-four buildings and the continued decay of the site, the story of the South Carolina State Sanatorium as an example of public health in the segregated South becomes even more pertinent today.

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