

# From Exclusion to Expulsion: Mexicans and Tuberculosis Control in Los Angeles, 1914–1940

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**SUMMARY:** Even before the influx of Mexicans, public health officials in Los Angeles constructed very sick and very poor tubercular people as an illegitimate presence who not only endangered others but also represented weakness and failure and imposed intolerable economic burdens. The identification of tuberculosis with Mexicans during the 1920s hardened the perception that they did not belong in Los Angeles. Because Mexicans lived and worked in dangerous surroundings, it is likely that they bore a very high burden of tuberculosis. Contemporary statistics, however, tell us less about the prevalence of disease than about the attitudes of health officials. Most were convinced that Mexicans had an innate susceptibility to tuberculosis. Concerns about the cost of supporting tubercular Mexicans figured prominently in efforts to restrict their immigration in the 1920s, and in the deportation and repatriation drives of the 1930s.

**KEY WORDS:** Mexicans, tuberculosis, immigration, public health history

In the mid-1920s, the California State Board of Health published two widely circulated reports that helped to shape the discourse surrounding Mexicans during the subsequent decade and a half. The first, *A Statistical Study of Sickness among the Mexicans in the Los Angeles County Hospital, from July 1, 1922 to June 30, 1924*, appeared in 1925. It opened with an

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introduction by Edythe Tate Thompson, the director of the Bureau of Tuberculosis. Thompson began by noting that the newly passed immigration law “does not help California” because it failed to impose a quota for Mexicans.<sup>1</sup> Employers insisted that they needed to import a “cheap” source of labor, but high rates of tuberculosis meant that Mexicans were not costless to the state. Thompson attributed the prevalence of tuberculosis to a variety of factors: their homes were poorly constructed; because they had large families, they spread germs among themselves; they ate “badly balanced” diets; they refused to abide by public health recommendations; and their bodies were especially susceptible to the disease.<sup>2</sup>

Deportation was always a possibility, but it offered inadequate protection because of the length and porosity of the border. The only acceptable solution was for the federal government to limit the ports of entry and to provide more-rigorous medical examinations. One example highlighted the danger of unrestricted immigration:

Last year an aged Mexican in the last stages of tuberculosis came across the border unattended and of course unexamined, and a few hours later he was sent to the already overcrowded ward of the tuberculosis hospital. He was put to bed and on the second day decided he would not stay in bed in spite of a fever of 104 degrees, so he left the hospital and later was picked up on the street again and returned. . . . While the patient was waiting to be readmitted, he died. The incident was most unfortunate, the hospital was blamed, yet the episode of dying people entering this country is not unusual.<sup>3</sup>

The remainder of the report consisted of a series of statistical tables showing the cost of caring for tubercular Mexicans in the local county hospital. Between 1922 and 1924, Mexicans spent a total of 122,033 days in the hospital, at a cost to the county of \$328,075. Tuberculosis represented 14 percent of all admissions; the cost to the county of care for Mexicans with tuberculosis was \$75,141.<sup>4</sup>

The following year, the State Board of Health published a second study, entitled *Summary of Mexican Cases Where Tuberculosis Is a Problem*. Once again, Thompson wrote an introduction stressing the need for immigration control. The statistical segment consisted of tables compiled by R. R. Miller, superintendent of the Outdoor Relief Division of the Los Angeles County Department of Charities, indicating that 374

1. Edythe Tate Thompson, “Introduction,” in California Bureau of Tuberculosis, *A Statistical Study of Sickness among the Mexicans in the Los Angeles County Hospital, from July 1, 1922 to June 30, 1924* (Sacramento: California State Printing Office, 1925), n.p.

2. *Ibid.*

3. *Ibid.*

4. *Ibid.*

Mexican families in Los Angeles “where tuberculosis is a problem” received county relief and/or state aid. (The Mothers Pension Act of 1921 provided \$10 a month for children whose fathers could not work because of tuberculosis.) The annual expenditure for the 374 families was \$154,851.60; the total amount spent to date was \$292,406.54.<sup>5</sup>

Some themes in the two reports are very familiar to public health historians. Numerous historical studies have demonstrated the tendency of societies to identify dread diseases with foreigners. During the late nineteenth and early twentieth centuries, East Coast officials associated various contagious diseases with immigrants, even in the face of epidemiologic falsification, and fought to limit their entry into the country.<sup>6</sup> It thus is hardly surprising that Thompson stressed the prevalence of tuberculosis among Mexicans, depicted them as the agents of disease rather than its victims, and called for tighter border control.

But the reports also highlight two themes that deserve further analysis from medical historians. One is the chronic nature of tuberculosis. Several recent studies have enormously enlarged our understanding of how the gradual acceptance of the germ theory transformed the medical treatment, social situation, and cultural representation of people with tuberculosis during the early twentieth century.<sup>7</sup> I argue that contemporaries also feared the disease because it disabled victims for years. The bulk of both reports focused on Mexicans not as disease carriers but rather as economic burdens. To be sure, it was easier to quantify the costs of hospital days and monetary relief than to estimate the extent or rapidity of the spread of germs. Nevertheless, the emphasis of the reports

5. California State Board of Health, *Summary of Mexican Cases Where Tuberculosis Is a Problem* (Sacramento: California State Printing Office, 1926), n.p.

6. Among the many studies discussing this issue are Alan M. Kraut, *Silent Travelers: Germs, Genes, and the “Immigrant Menace”* (New York: Basic Books, 1994); Judith Walzer Leavitt, *Typhoid Mary: Captive to the Public’s Health* (Boston: Beacon Press, 1996); Howard Markel, *Quarantine! East European Jewish Immigrants and the New York City Epidemics of 1892* (Baltimore: Johns Hopkins University Press, 1997); Naomi Rogers, *Dirt and Disease: Polio before FDR* (New Brunswick, N.J.: Rutgers University Press, 1992).

7. Barbara Bates, *Bargaining for Life: A Social History of Tuberculosis, 1876–1938* (Philadelphia: University of Pennsylvania Press, 1992); Mark Caldwell, *The Last Crusade: The War on Consumption, 1862–1954* (New York: Atheneum, 1988); Georgina D. Feldberg, *Disease and Class: Tuberculosis and the Shaping of Modern North American Society* (New Brunswick, N.J.: Rutgers University Press, 1995); Barron H. Lerner, *Contagion and Confinement: Controlling Tuberculosis along the Skid Road* (Baltimore: Johns Hopkins University Press, 1998); Katherine Ott, *Fevered Lives: Tuberculosis in American Culture since 1870* (Cambridge: Harvard University Press, 1996); Sheila M. Rothman, *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: Basic Books, 1994); Michael E. Teller, *The Tuberculosis Movement: A Public Health Campaign in the Progressive Era* (New York: Greenwood Press, 1988).

reminds us that financial concerns weighed heavily in discussions of tuberculosis among Mexicans.

The second topic demanding greater attention is immigration into the Southwest. Most historians of tuberculosis focus exclusively on immigrants who departed from eastern and southern Europe and settled in East Coast cities between 1880 and 1920.<sup>8</sup> Immigration from Mexico occurred later and raised a very different set of issues. In this essay I suggest that the association with tuberculosis had an even more devastating impact on Mexicans in Los Angeles than on the European immigrants on the East Coast whom medical historians previously have examined.

### Strategies of Exclusion

The two reports appeared in the midst of a vast migration of Mexicans into Los Angeles. Pushed by unsettled economic and political conditions at home and pulled by the labor demands of American employers, thousands of Mexicans poured into the city and county. There they encountered what Jules Tygiel describes as “a land of harsh discrimination.”<sup>9</sup> Local chapters of the Ku Klux Klan attracted sizable followings.<sup>10</sup> Employers hired only native-born Anglos in white-collar positions, restricting the new immigrants to the lowest-paid, most dangerous, and least secure jobs.<sup>11</sup> Edward Roybal later recalled seeing signs on public accommodations stating “No Mexicans or Negroes Allowed.”<sup>12</sup> Whites were privileged in death as in life: Forest Lawn buried only those “of Caucasian descent.”<sup>13</sup> As Mexicans became the largest ethnic minority group in the 1920s, they also became the primary focus of discrimination. We will see that Edythe Tate Thompson’s two reports played a critical role in efforts to define that group as an alien presence.

8. The major exception is Lerner, *Contagion and Confinement* (n. 7). Two recent dissertations discussing public health in Los Angeles are Jennifer Koslow, “Eden’s Underbelly: Female Reformers and Public Health in Los Angeles, 1889–1932” (Ph.D. diss., UCLA, 2001); and Natalia Molina, “Contested Bodies and Cultures: The Politics of Public Health and Race within Mexican, Japanese, and Chinese Communities in Los Angeles, 1879–1939” (Ph.D. diss., University of Michigan, 2001).

9. Jules Tygiel, “Introduction: Metropolis in the Making: Los Angeles in the 1920s,” in *Metropolis in the Making: Los Angeles in the 1920s*, ed. Tom Sitton and William Deverell (Berkeley: University of California Press, 2001), pp. 1–11, quotation on p. 8.

10. *Ibid.*

11. Clark Davis, “The View from Spring Street: White Collar Men in the City of Angels,” in Sitton and Deverell, *Metropolis in the Making* (n. 9), pp. 179–98.

12. Cited in Robert V. Hine and John Mack Faragher, *The American West: A New Interpretive History* (New Haven: Yale University Press, 2000), p. 427.

13. David Charles Sloane, “Selling Eternity in 1920s Los Angeles,” in Sitton and Deverell, *Metropolis in the Making* (n. 9), pp. 341–60.

Tuberculosis had long preoccupied Los Angelenos. A brief history of their changing attitudes toward the disease can help to explain the focus of Thompson's reports. During the mid-nineteenth century, large numbers of East Coast sufferers traveled west, seeking the return of health in the land associated with regeneration and renewal.<sup>14</sup> The completion of the transcontinental railroad in 1869 softened the rigors of the trip, opened the journey to far more people, and made southern California a major destination. Cities and towns increasingly vied with other parts of the Southwest for the invalid trade. A major theme in southern Californian booster writing was the healing power of work in the newly planted citrus orchards. One former invalid proclaimed: "Steady, persistent cultivation of the soil, in a pure atmosphere and under a genial sky, like we have here, will as surely save from destruction any lungs capable of salvation, as faith will save the soul."<sup>15</sup> An 1883 guidebook was entitled *California for Fruit Growers and Consumptives*.<sup>16</sup>

After the turn of the century, however, California, like other states with large concentrations of health-seekers, gradually withdrew its welcome. Health officials continued to argue that health was California's normal condition, but they also circulated statistics showing the high prevalence of tuberculosis. Concluding that health-seekers were responsible for importing a dread disease, officials insisted that the state close its borders. In 1900, the California State Board of Health urged the legislature to deny admission to all tubercular people.

Although that proposal failed—largely because it was so patently impractical—policymakers sought to impose a quarantine by other means. During the mid-1910s the Bureau of Tuberculosis, led by Edythe Tate Thompson, posted warnings in East Coast railroad stations, clinics, and employment agencies stating that California had no free beds for non-residents and that they should come only if they had a year's financial support.<sup>17</sup> At the behest of the State Board of Health, California Congressmen introduced a 1916 bill stipulating that tubercular people who were nonresidents would be either sent back to their homes or supported in part by the federal government; as the Secretary of the Board of Health stated, one of the primary goals of the law was to "discourage

14. Feldberg, *Disease and Class* (n. 7); Ott, *Fevered Lives* (n. 7); Rothman, *Living in the Shadow of Death* (n. 7).

15. Quoted in John E. Baur, *The Health Seekers of Southern California, 1870–1900* (San Marino: Huntington Library, 1959), p. 119.

16. Cited in Rothman, *Living in the Shadow of Death* (n. 7), p. 147.

17. *Thirty-first Biennial Report of the Department of Public Health of California for the Fiscal Years from July 1, 1928 to June 30, 1930* (Sacramento: California State Printing Office, 1930), pp. 128–29.

migration.”<sup>18</sup> The Board of Health also responded quickly and angrily to reports in 1918 that the Army was furnishing cash to men rejected because of tuberculosis and encouraging them to travel west in search of a good climate and appropriate work: the Board wrote letters to various federal officials urging that the men instead be given tickets home, and Thompson was dispatched to Washington to plead the case in person.<sup>19</sup>

Actions in Los Angeles supplemented those at the state level. In 1912, the Los Angeles City Council passed a zoning ordinance prohibiting any city hospital from caring for tubercular patients. The County Board of Supervisors went further, expelling tuberculosis sufferers and not just excluding them. Invoking the principle of local responsibility for indigents, the Board enacted a rule in 1909 that tubercular people who applied for public assistance would instead be given one-way train fares. Four years later, the Department of Charities returned forty-five tubercular patients and their families, and private charitable agencies transported an additional hundred.<sup>20</sup>

The growing understanding of the communicable nature of tuberculosis provides one key to this eager embrace of exclusionary strategies: as a result of the discovery of the tubercle bacillus and widespread publicity about the germ theory, tuberculosis sufferers increasingly were feared as menaces.<sup>21</sup> But other explanations of the dramatic policy change are equally compelling. It is important to note that the public increasingly focused on two types of tubercular people: those with advanced disease, and those who lacked financial resources. One argument against the statewide quarantine was that it would affect all health-seekers equally. As a southern California physician wrote in 1906, “No harm can come to California from the decent and orderly settlement of consumptives within her borders.”<sup>22</sup> Danger arose only from those who “swarm upon her soil from the East,” a group consisting of “consumptives unable to provide themselves with the necessities of life or . . . palpably stricken with

18. Statement of Wilbur A. Sawyer, Secretary of the State Board of Health, California, in U.S. Senate Committee on Public Health and National Quarantine, *Hearings on S.R. 3202*, 64th Cong., 1st sess., 1916.

19. Minutes of the California State Board of Health, January 1918, March 1918, January 1920, California State Archives, Sacramento, Calif. (henceforth CSAS); *Biennial Report of the California State Board of Health for 1922–24* (Sacramento: California State Printing Office, 1924), p. 63.

20. P. M. Carrington, “Interstate Migration of Tuberculous Persons: Its Bearing on the Public Health with Reference to the State of California,” *Pub. Health Rep.*, 19 March 1915, pp. 826–41, on pp. 840, 835.

21. Rothman, *Living in the Shadow of Death* (n. 7).

22. “The Southern California Anti-Tuberculosis League,” *Southern California Practit.*, 1906, 21: 466–67, quotation on p. 466. (The author’s name is not provided.)

death.”<sup>23</sup> Successful exclusionary proposals were carefully targeted toward the very sick and the very poor.

To be sure, a major reason for trying to deter such people was that they were assumed to be especially dangerous. It was widely believed that the sputum of those with advanced disease was most likely to infect others.<sup>24</sup> The very poor were viewed as being especially prone to spread disease because they lived in cheap lodging houses, were “ignorant” and “vicious,” and failed to comply with public health advice.<sup>25</sup>

But the virulence of the rhetoric surrounding poor tubercular people and those with late stages of disease reflected other concerns as well. Late nineteenth- and early twentieth-century culture idealized strength and toughness, which were equated with masculinity.<sup>26</sup> Many nineteenth-century health-seekers were single men who told stories of going from weakness to strength, conquering tuberculosis while conquering other forms of nature. Such health-seekers defined themselves in opposition to less successful invalids, who were imbued with uniformly negative traits such as passivity and fatalism.<sup>27</sup> Similar values infused the writings of early twentieth-century health officials. Thompson, for example, described the “hopelessly ill” as a pathetic group who lacked willpower and deserved only the least attractive, custodial care.<sup>28</sup>

Poor tubercular people were viewed as economic burdens. Many physicians and civic leaders noted that because the disease frequently led to impoverishment, patients and their families figured prominently among the recipients of private charity and public relief. After surveying the condition of “the indigent consumptive” in the Southwest, Ernest A. Sweet, a former assistant surgeon in the U.S. Public Health Service, concluded: “It is not alone because he is a sufferer from tuberculosis that he is unwelcome, but because he is a pauper as well.”<sup>29</sup>

23. *Ibid.*, p. 467.

24. Barbara Gutmann Rosenkrantz, “Introductory Essay: Dubos and Tuberculosis, Master Teachers,” in René and Jean Dubos, *The White Plague: Tuberculosis, Man, and Society* (New Brunswick, N.J.: Rutgers University Press, 1987), pp. xiii–xxxiv, quotation on p. xxviii.

25. See *Report of the California Tuberculosis Commission of the State Board of Health*, Sacramento, California (Sacramento: State Printing Office, 1914).

26. See Gail Bederman, *Manliness and Civilization: A Cultural History of Gender and Race in the United States, 1880–1917* (Chicago: University of Chicago Press, 1995); Matthew Basso, Laura McCall, and Dee Garceau, eds., *Across the Great Divide: Cultures of Manhood in the American West* (New York: Routledge, 2001).

27. A good example is George F. Weeks, *California Copy* (Washington, D.C.: Washington College Press, 1928).

28. See “Tuberculosis—Monthly Reports, 1933–1940,” CSAS.

29. Ernest A. Sweet, “Interstate Migration of Tuberculous Persons: Its Bearing on the Public Health, with Special Reference to the States of Texas and New Mexico,” *Pub. Health Rep.*, 16 April 1915, pp. 1147–73, quotation on p. 1159.

Los Angelenos may have been especially fervent proponents of exclusion not only because their metropolis attracted many health-seekers, but also because its mythology changed greatly after 1900. As residential subdivisions uprooted the orchards, Los Angeles increasingly was advertised as a haven of safety for middle-class families, rather than as a site of renewal for single invalids.<sup>30</sup> The image of widespread, incurable tuberculosis was not what real estate agents and developers wanted to present to potential home buyers.

Moreover, exclusivity and segregation are the hallmarks of suburbs. Many Los Angeles subdivisions imposed restrictive covenants that prohibited African Americans, Asians, Mexicans, and Jews, and mandated minimum housing costs—thus ensuring, as one developer put it, that homeowners were “people of more or less like income.”<sup>31</sup> In 1908, Los Angeles pioneered the use of zoning laws, separating business and commercial enterprises from the “best” residential areas.<sup>32</sup> During the following few years, the city gradually extended the scope of the laws. As already noted, a 1912 ordinance prohibited hospital care of tuberculosis patients anywhere within the city limits; because poor people increasingly were associated with that disease, the law may have represented an attempt to exclude simultaneously a terrible scourge and the “wrong” kind of people.

Despite fears that public services would serve as a magnet for health-seekers, health officials gradually established tuberculosis programs. Founded in 1878, Los Angeles General Hospital created separate wards for tuberculosis patients in 1912.<sup>33</sup> A 1923 bond issue raised funds for a new building, which opened in 1933.<sup>34</sup> The genesis of Olive View, the county sanatorium, was a 1915 state law providing a subsidy of \$3 a week for the institutional care of indigent tuberculosis patients. Construction began on a site in the San Fernando Valley in 1918, and the first 95

30. On early twentieth-century booster writing, see Clark Davis, “From Oasis to Metropolis: Southern California and the Changing Context of American Leisure,” *Pacific Hist. Rev.*, 1992, 61: 357–86; Kevin Starr, *Inventing the Dream: California through the Progressive Era* (New York: Oxford University Press, 1985); Tom Zimmerman, “Paradise Promoted: Boosterism and the Los Angeles Chamber of Commerce,” *California History*, 1985, 64: 22–23.

31. Robert M. Fogelson, *Fragmented Metropolis: Los Angeles, 1850–1930* (Cambridge: Harvard University Press, 1967), p. 145.

32. Marc A. Weiss, *The Rise of the Community Builders: The American Real Estate Industry and Urban Land Planning* (New York: Columbia University Press, 1987), p. 13.

33. Until 1923, this facility was called the Los Angeles County Hospital: Helen Eastman Martin, *The History of Los Angeles County Hospital, 1878–1968 and the Los Angeles County–University of Southern California Medical Center, 1969–1978* (Los Angeles: University of Southern California Press, 1979), p. 47.

34. *Ibid.*, pp. 21–143.



patients were admitted in 1920; the facility grew almost continually until 1931, when capacity reached 971.<sup>35</sup> In addition, by 1915 both the county and city health departments had begun to establish separate tuberculosis clinics and to hire public health nurses to advise tuberculosis patients. As the number of programs grew, complaints about tuberculosis patients as financial liabilities increasingly focused on the high cost of the services they consumed.

In short, even before the influx of Mexicans, officials had constructed very sick and very poor tubercular people as an illegitimate presence who not only endangered others but also represented weakness and failure and imposed unbearable economic burdens. In the following section I show that the identification of tuberculosis with Mexicans during the 1920s hardened the perception that they did not belong in Los Angeles.

### Targeting Mexicans

Because Mexicans lived and worked in dangerous surroundings, it is likely that they bore a very high burden of tuberculosis. Contemporary statistics, however, tell us less about the prevalence of disease than about the attitudes of health officials. Dr. Gladys Patric was the first to call attention to the high level of tuberculosis in Mexican communities, reporting in 1918 that more than a third of the houses in the North Main district had at least one case.<sup>36</sup> Because the diagnosis of tuberculosis remained inexact throughout the early twentieth century, however, these findings are open to challenge.<sup>37</sup> (The same problem, of course, undermines the data published in the *Statistical Summary* and the *Summary of Mexican Cases*.) Beginning in the early 1920s, the County Health Department released annual tuberculosis morbidity data. A typical comment comes from the 1936–37 report: “Attention must be drawn to the fact that Mexicans make up 22.5 per cent of the cases, which shows that the disease is greatly out of the proportion to their percentage of the population, which is approximately 10 per cent.”<sup>38</sup> Here the difficulties of

35. “18th Annual Report of Olive View Sanatorium, 1936–37,” p. 3, file 40.20/337, Files of the Los Angeles County Board of Supervisors, Hall of Administration, Los Angeles, Calif. (henceforth LACBS).

36. Gladys Patric, *A Study of the Housing and Social Conditions in the Ann Street District of Los Angeles, California* (Los Angeles: Los Angeles Society for the Study and Prevention of Tuberculosis, 1917).

37. See Linda Bryder, “‘Not Always One and the Same Thing’: The Registration of Tuberculosis Deaths in Britain, 1900–1950,” *Soc. Hist. Med.*, 1996, 9 (2): 253–65.

38. “Annual Report of the Los Angeles County Health Department for 1936–37,” p. 7, file 180.3, LACBS.

estimating the size of the Mexican population compounded diagnostic problems. Edward J. Escobar notes that before 1930, estimates by historians who use census records and city directories “vary by as much as 300 percent.”<sup>39</sup> We can assume that the estimates of contemporaries, relying on cruder methods, had even less validity.

Moreover, preconceptions about Mexicans as tubercular appear to have inflated the statistics, which then were used to prove the point. Recalling her girlhood in the San Fernando Valley in the late 1930s, Mary Helen Ponce wrote that school nurses assumed that every underweight Mexican child suffered from tuberculosis.<sup>40</sup> Mexican children also were especially likely to be the focus of school screening programs. The 1937–38 County Health Department report noted that elementary-school screening occurred only in districts “abounding in tuberculosis or such as were attended largely by racial or economic groups especially subject to the disease”; that same year, the department “started testing all Mexican infants under one year coming to our Baby Welfare Clinics, hoping that the reactors in this group will lead us to yet undetected cases.”<sup>41</sup> Similar preconceptions may have influenced the process of diagnosis as well as the target of screening. An autopsy study conducted in 1931 at Olive View Sanatorium found that Mexican lung problems were especially likely to be diagnosed as tuberculosis. According to the researcher, Emil Bogen, “several instances of carcinoma of the lungs and other non-tuberculous conditions have been found which had been clinically considered tuberculous”; this suggested to Bogen that “the cited high tuberculosis rates among the Mexicans may be due in part to oftener missed diagnoses of other conditions.”<sup>42</sup>

The county data also had a clear class bias. Although California required physicians to report tuberculosis starting in 1908,<sup>43</sup> compliance was far from perfect, especially in the early years. Some doctors may simply have been negligent; some may have resented any official incursions into their autonomy; and some may have succumbed to the pres-

39. Edward J. Escobar, *Race, Police, and the Making of a Political Identity: Mexican Americans and the Los Angeles Police Department, 1900–1945* (Berkeley: University of California Press, 1999), p. 122.

40. Mary Helen Ponce, *Hoyt Street, An Autobiography* (Albuquerque: University of New Mexico Press, 1993), p. 228.

41. “Annual Report of the Los Angeles County Health Department for Year Ended June 30, 1938,” p. 18, file 180.3/414, LACBS.

42. Emil Bogen, “Racial Susceptibility to Tuberculosis,” *Amer. Rev. Tuberc.*, 1931, 24 (4): 522–31, quotation on p. 523.

43. *Twentieth Biennial Report of the State Board of Health of California for the Fiscal Years from July 1, 1906 to June 30, 1908* (Sacramento: California State Printing Office, 1924), p. 21.

sure of patients who wanted to conceal tuberculosis in order to avoid the stigma surrounding it.<sup>44</sup> While death certificates tended to provide more accurate information, morbidity data, too, may have exaggerated the proportion of Mexican cases. Many life insurance companies denied benefits to families in cases of tuberculosis, and it therefore is likely that some physicians recorded other causes of death in deference to the wishes of survivors<sup>45</sup>—and because many Mexicans were too poor to consult private physicians or purchase life insurance, they may have been especially likely to be labeled tubercular in official reports.

Health authorities offered various explanations for the high rates of tuberculosis they found among Mexicans. We have seen that although Thompson acknowledged the role of housing, she focused on the same mix of personal habits that her contemporaries implicated in the genesis of other communicable diseases. Her emphasis on health-threatening behaviors was typical of the time. By the 1920s, the tuberculosis movement had lost much of the social reform fervor that had infused it throughout the Progressive Era; experts thus paid relatively little attention to the harsh conditions in which victims lived and labored.<sup>46</sup>

One factor that Thompson mentioned is especially noteworthy: The biology of Mexicans, she insisted, made them especially vulnerable to tuberculosis. As previous historians note, contemporaries pointed to high rates of the disease among African Americans and American Indians as evidence that they were “primitive” people who lacked prior exposure and thus never had developed immunity.<sup>47</sup> Not surprisingly,

44. See Elizabeth Fee and Evelyn M. Hammonds, “Science, Politics, and the Art of Persuasion: Promoting the New Scientific Medicine in New York City,” in *Hives of Sickness: Public Health and Epidemics in New York City*, ed. David Rosner (New Brunswick, N.J.: Rutgers University Press, 1995), pp. 155–96; Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), p. 187.

45. See Bryder, “‘Not Always One and the Same Thing’” (n. 37).

46. See Lerner, *Contagion and Confinement* (n. 7); Nancy Tomes, *The Gospel of Germs: Men, Women, and the Microbe in American Life* (Cambridge: Harvard University Press, 1998).

47. See Allan M. Brandt, “Racism and Research: The Case of the Tuskegee Syphilis Study,” *Hastings Center Rep.*, 1978, 8 (2): 21–29; Brian W. Dippie, *The Vanishing American: White Attitudes and U.S. Indian Policy* (Middletown, Conn.: Wesleyan University Press, 1982); Ott, *Fevered Lives* (n. 7), pp. 100–110; Marion M. Torchia, “Tuberculosis among American Negroes: Medical Research on a Racial Disease, 1830–1950,” *J. Hist. Med. & Allied Sci.*, 1977, 32: 252–79. See also Douglas C. Baynton, “Disability and the Justification of Inequality in American History,” in *The New Disability History, American Perspectives*, ed. Paul K. Longmore and Lauri Umansky (New York: New York University Press, 2001), pp. 33–57. On contemporary notions about racial susceptibility to disease among colonial populations, see Warwick Anderson, “Immunities of Empire: Race, Disease, and the New Tropical Medicine,

experts seeking to understand the prevalence of tuberculosis among Mexican immigrants emphasized their Indian makeup. In a discussion of tuberculosis in the Southwest, Sweet wrote:

The Mexicans are possessed of an extremely low racial immunity, which is probably due to the large admixture of Indian blood. Their resistance has never been developed, because they have never fought the infection through successive generations. Just as in children the susceptibility decreases as age increases, so in races the further removed they are from civilization, the more susceptible they are to the disease.<sup>48</sup>

Sweet also argued that tuberculosis advanced especially rapidly among Mexicans: "Recoveries are exceedingly rare, most physicians confessing never to have seen one, and the course is almost invariably progressively downward. A person will be about his work apparently well, suffer from a hemorrhage, and in four months he will be dead"; by contrast, he concluded, Mexicans who were "less contaminated by Indian blood" exhibited "far more resistance to the disease."<sup>49</sup>

The argument that Mexican bodies were especially prone to tuberculosis and succumbed rapidly to its ravages served two purposes: In an era that idealized strength and vigor, the argument enabled whites to view Mexicans as inherently weak, despite the arduous physical labor in which they engaged. And it contributed to the growing campaign to construct Mexicans as a racial group, not simply a national one.<sup>50</sup>

In raising the alarm about the prevalence of tuberculosis among Mexicans and suggesting that biological vulnerability was an important cause, Thompson was thus expressing views that were widespread. The timing of her two reports further helps us understand their import: both appeared shortly after the passage of the Immigration Act of 1924, which instituted numerical quotas for European immigrants.<sup>51</sup> As Thompson

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1900–1920," *Bull. Hist. Med.*, 1996, 70: 94–118; Mark Harrison and Michael Worboys, "A Disease of Civilization: Tuberculosis in Britain, Africa, and India, 1900–1939," in *Migrants, Minorities and Health: Historical and Contemporary Studies*, ed. Lara Marks and Michael Worboys (London: Routledge, 1997), pp. 93–124.

48. Ernest A. Sweet, "Interstate Migration of Tuberculous Persons: Its Bearing on the Public Health, with Special Reference to the States of Texas and New Mexico," *Public Health Rep.*, 1915, 30 (17): 1225–55, quotation on p. 1239. On contemporary notions about "civilization," see Bederman, *Manliness and Civilization* (n. 26).

49. Sweet, "Interstate Migration" (n. 48), p. 1240.

50. On the racial formation of Mexicans, see Mae M. Ngai, "Illegal Aliens and Alien Citizens: United States Immigration Policy and Racial Formation, 1924–1945" (Ph.D. diss., Columbia University, 1996).

51. See Mae M. Ngai, "The Architecture of Race in American Immigration Law: A Reexamination of the Immigration Act of 1924," *J. Amer. Hist.*, 1999, 86: 67–92.

wrote in her introduction to the *Statistical Study*, the absence of a quota for immigrants from the Western Hemisphere meant that the act “does not help California.” The act did, however, profoundly alter the status of Mexicans. Mae M. Ngai demonstrates that the legislation precipitated the passage of various measures to tighten the border between Mexico and America and to penalize those who entered unofficially.<sup>52</sup> Deportations rose from 1,751 in 1925 to over 15,000 in 1929, more than an eightfold increase.<sup>53</sup> Thompson’s statement that deportation offered one remedy to the problems imposed by Mexicans with tuberculosis suggests that she endorsed those removals.

Thompson’s emphasis on tubercular Mexicans as economic burdens rather than as disease carriers also makes sense within this context. It was common to note that tuberculosis was a communicable, not a contagious, disease.<sup>54</sup> Moreover, as Thompson later remarked, Mexicans interacted with whites relatively infrequently.<sup>55</sup> But above all, she was writing in opposition to growers who claimed to need Mexican labor and thus sought to keep the border open. Her contention was that employers’ calculations ignored the enormous expenses that Mexicans imposed on the state. She also undoubtedly was aware that concerns about economic dependency had long dominated immigration policy. Amy L. Fairchild demonstrates that the main reason immigration authorities categorized tuberculosis as an “excludable condition” was not fear of the germs that victims spread, but rather the belief that they were “likely to become a public charge.”<sup>56</sup> We have seen that similar considerations underlay the campaign to stem the tide of invalids into southern California.

Thompson’s own proposal for securing the border was for the federal government to institute more-thorough medical inspections at El Paso, the primary port of entry for Mexicans in the Southwest. Although that port had begun to establish medical examinations in 1916, the inspectors stopped very few people.<sup>57</sup> The belief that more-rigorous examinations could ameliorate Los Angeles’s problems, of course, rested on the assumption that immigrants imported tuberculosis—an assumption that was not universally accepted. After reporting fifty-nine tuberculosis deaths

52. Ngai, “Illegal Aliens and Alien Citizens” (n. 50).

53. Mae Ngai, “The Strange Career of the Illegal Alien: Immigration Restriction and Deportation Policy in the United States, 1921–1965,” *Law & Hist. Rev.*, 2003, 21(1): 69–108.

54. See Amy L. Fairchild, *Science at the Borders: Immigrant Medical Inspection and the Shaping of the Modern Industrial Labor Force, 1891 to 1930* (Baltimore: Johns Hopkins University Press, 2003).

55. “Tuberculosis—Monthly Reports” (n. 28), 17 September 1934.

56. Fairchild, *Science at the Borders* (n. 54), pp. 165–74.

57. See *ibid.*

among Mexicans in 1916, John L. Pomeroy, the director of the Los Angeles County Department of Health, wrote that they had “contracted the disease for the most part in California.”<sup>58</sup> Governor C. C. Young’s “Mexican Fact-Finding Committee” would reach a similar conclusion in 1930. Relying on 1926 charity cases in Los Angeles County, the report noted that seven-eighths of the heads of Mexican families with tuberculosis had been born in Mexico; four-fifths, however, had lived in the United States for more than five years—indicating to the committee that infection had occurred here.<sup>59</sup> Indeed, the belief that tuberculosis was imported contradicted the assertion that Mexican susceptibility resulted from lack of exposure. Thompson’s evidence was primarily anecdotal. Recall her highly improbable account of an elderly migrant crossing the border and then traveling to Los Angeles in the final stages of disease, and her statement that the incident was “not unusual.” In 1928, she again suggested that such cases were common: “There is often the case of the man who has been brought in as part of a construction gang and who has had a hemorrhage and been taken off at the first stop in California, and who perhaps lived only a few days.”<sup>60</sup> The typical Mexican who crossed the border, she implied, was not the healthy worker whom employers sought, but rather the invalid who had no productive capacity and consumed scarce public resources.

The two reports published by Thompson were used extensively in efforts to expand the quota system to include Mexicans. In January 1928 she mailed several copies of the *Statistical Study* and *Summary of Mexican Cases* to Albert Johnson, urging him to distribute them to members of the House Immigration Committee, which he chaired.<sup>61</sup> On 1 February 1930 she wrote again, sending him “some information that will show what Mexicans are costing certain sections of the state.”<sup>62</sup> Two weeks later, she congratulated Johnson “on the splendid fight that you have made so successfully on the quota” and indicated that she would be “glad” to “furnish any additional information.”<sup>63</sup>

58. “Department of Health, Los Angeles County, Quarterly Report for December 31, 1916,” p. 4, file OD1217H, LACBS.

59. *Mexicans in California: Report of Governor C. C. Young’s Mexican Fact-Finding Committee* (San Francisco, October 1930), p. 187.

60. Edythe Tate Thompson, “Public Health among the Mexicans” (Paper read at the Annual Conference of the Friends of Mexico, Pomona College, 17 November 1928), HR 71A–F16.4, National Archives, Washington, D.C. (henceforth NAW).

61. Edythe Tate Thompson to Albert Johnson, 17 January 1928, HR 70A–F14.3, NAW.

62. Thompson to Johnson, 1 February 1930, HR 71A–F16.2, NAW.

63. Thompson to Johnson, 18 February 1930, *ibid.*

Thompson was not alone in her support of restriction. Emory S. Bogardus, a sociologist at the University of Southern California, noted that “social and public health workers” were an important group demanding extension of the quota.<sup>64</sup> Many claimed special expertise about Mexicans. Sixty-one public health nurses and social workers in Los Angeles signed a petition stating that they had “extensive and intimate knowledge of our foreign born population” and “believe[d] in immigration restriction, as necessary to maintain the unity and safety of our country.”<sup>65</sup> A. S. Baker, a physician at the Los Angeles County Department of Health East Side Health Center, wrote to Johnson on behalf of a group of doctors and dentists who “are in close touch with the situation on the east side of Los Angeles (Belvedere and Maravilla Park) which is rapidly becoming intolerable to American tax payers,” and who “feel especially qualified to speak on the subject.”<sup>66</sup>

State and local officials also were important players in the hearings organized by Representative John C. Box of Texas on the bill to limit immigration from Mexico. John L. Pomeroy, for example, stated: “Unless the tubercular and venereal Mexican is cared for through the public health department he is likely to become a public health problem of sufficient size to affect the general public health.”<sup>67</sup> Others testifying at the hearings portrayed Mexicans as economic burdens, pointing over and over to statistics from the two reports Thompson had circulated so effectively throughout the country.<sup>68</sup>

## The Impact of the Depression

The Great Depression had an especially devastating effect on Mexicans in Los Angeles. Although Mexicans were the first to lose jobs, many state and local relief efforts gave priority to whites; some excluded all

64. Emory S. Bogardus, *The Mexican in the United States* (Los Angeles: University of Southern California Press, 1934), p. 84.

65. Petition, 4 June 1928, RG 233, Committee Papers, HR 70A–F14.3, NAW.

66. A. S. Baker to Albert Johnson, 30 January 1928, *ibid.*

67. U.S. House Committee on Immigration and Naturalization, *Western Hemisphere Immigration: Hearings on H.R. 8523, H.R. 8530, H.R. 8702, to Limit the Immigration of Aliens to the United States, and for Other Purposes*, 71st Cong., 2d sess., 1929, p. 407.

68. U.S. House Committee on Immigration and Naturalization, *Immigration from Countries of the Western Hemisphere: Hearings on H.R. 6465, H.R. 7358, H.R. 10955, H.R. 1168*, 70th Cong., 1st sess., 21 February to 5 April 1928, Hearing no. 70.1.5, pp. 52, 59, 64, 90; *idem*, *Seasonal Agricultural Laborers from Mexico: Hearing on H.R. 6741, H.R. 7559, H.R. 9036*, 69th Cong., 1st sess., 28 and 29 January, 2, 9, 11, and 23 February 1926, Hearing no. 69.1.7, pp. 15, 319.

noncitizens.<sup>69</sup> The Los Angeles County Department of Charities continued to provide relief to Mexicans, but cut their allotments by 20 percent in 1933; the primary rationale—that they spent less than whites on food—was especially ironic in view of the repeated claim that high rates of tuberculosis stemmed partly from poor diets.<sup>70</sup>

The influential Young Report published in 1930 highlighted the financial burden of caring for tubercular Mexicans. Relying on the figures contained in the *Summary of Mexican Cases*, the report noted that Mexicans represented “nearly two-fifths of all tuberculosis cases in which county relief were granted”; in addition, “nearly a fourth of all Mexican relief cases involved tuberculosis,” compared to just one-tenth of all “non-Mexican cases.”<sup>71</sup> The Young Report also claimed that the cost of treating Mexicans in Los Angeles General Hospital had increased “more than a third” since the *Statistical Study* of 1925.<sup>72</sup> Such an expense—combined with that of caring for Mexicans in Olive View and in both city and county clinics—must have seemed especially indefensible as health-care funding declined. Because many people who previously had sufficient incomes to consult private physicians were forced to rely on public services, access problems intensified. In 1933, Edythe Tate Thompson reported that the city clinic was “turning an average of forty patients away daily.”<sup>73</sup> Two years later she noted that physicians frequently complained about “the long, long delay for admission” of tuberculosis patients to the county hospital.<sup>74</sup> Nonresidents now were entitled only to “emergency care,”<sup>75</sup> and tuberculosis patients had to be hemorrhaging in order to qualify.<sup>76</sup>

69. See George Sánchez, *Becoming Mexican American: Ethnicity, Culture, and Identity in Chicano Los Angeles, 1900–1945* (New York: Oxford University Press, 1993), pp. 211–12.

70. See Latin-American Protective League, “Resolution” (1933), file 40.31/821, LACBS. Earl Jensen, the superintendent of charities, stated in August 1933: “I think you will agree with me that we are giving some of the Mexicans more than they ever had in their lives, even when they worked. I don’t care if the President of Mexico comes here and tells me I am discriminating, we must discriminate as between the man who lives as these Mexicans and his needs in the past, as compared with another man who has always lived in a different environment” (Address at Meeting of Directors, Patriotic Hall, 28 August 1933, Papers of John Anson Ford, Huntington Library, San Marino, Calif.).

71. *Mexicans in California* (n. 59), p. 187.

72. *Ibid.*, p. 194.

73. “Tuberculosis—Monthly Reports” (n. 28), 7 September 1933.

74. *Ibid.*, January 1935.

75. Council of Social Agencies of Los Angeles, “A Study of Transients Applying for Medical Care at Free and Part-Pay Clinics in Los Angeles” (10 March 1937), file 40.31/1569, LACBS.

76. “Tuberculosis—Monthly Reports” (n. 28), 7 September 1938.



Quality also deteriorated as both the city and county reduced staffing levels. After visiting Olive View in 1936, Thompson wrote:

The economy campaign that has gone on for the past two and a half years has reduced the nursing force to the point where there has been so few night nurses on duty that some buildings were left entirely without nurses, or one nurse would have charge of as many as three buildings and have to walk a hundred yards between the buildings. Recently two girls died in a building where there was no nurse.<sup>77</sup>

Many patients who previously would have gained places at Olive View instead entered private rest homes. Scattered throughout the county, these facilities contracted with the Department of Charities to provide care, but report after report noted that they lacked the requisite equipment, supplies, nursing supervision, and medical attention.<sup>78</sup> Nevertheless, the number of rest home patients grew steadily, reaching 1,000 in 1938 (approximately the same number as in Olive View).<sup>79</sup>

Two measures reduced Mexican access to Olive View. Just as noncitizens were ineligible for several relief programs established during the early years of the Depression, so “aliens” had greater difficulty entering tuberculosis sanatoriums after a 1930 law restricted the state subsidy to citizens. The statistics from Olive View indicate that although Mexicans remained a high proportion of its patients, their composition changed dramatically. Most Mexicans in Los Angeles during the 1930s were non-citizens,<sup>80</sup> but the proportion of Mexican patients born in Mexico declined from 72 percent in 1927 to 30 percent in 1936.<sup>81</sup> (Because few Mexican immigrants became citizens, the place of birth could be considered a proxy measure for citizenship status.)

Local officials substituted home-based services for institutional care. In 1932, the Los Angeles County Health Department and the County Department of Charities cooperated in establishing the Huntington Park

77. *Ibid.*, 8 September 1936.

78. Robert E. Plunkett, “A Survey of Tuberculosis Control Programs in Los Angeles County” (1937), p. 17, History Division, Biomedical Library, UCLA; “18th Annual Report of Olive View Sanatorium, 1936–37” (n. 35); John L. Pomeroy to Los Angeles County Board of Supervisors, 17 December 1935, file 180.3/310, LACBS; Edythe Tate Thompson to Board of Supervisors, 6 August 1935, file 40.20/233.6, LACBS; Everett J. Gray to Board of Supervisors, 28 April 1936, file 40.20/274, LACBS; H. F. Scoville to Board of Supervisors, 25 August 1938, file 40.20/338, LACBS.

79. Gray to Board of Supervisors, 28 April 1936 (n. 78).

80. W. F. French to Rex Thomson, 24 April 1934, file 55853, RG 85, NAW.

81. W. H. Holland to J. H. Bean, 4 February 1927, file 40.20/75, LACBS; “17th Annual Report of Olive View Sanatorium, 1935–36,” file 40.20, LACBS.

Mexican Colony, a home care program for tuberculosis patients. The targeted area was “a small, poor, typical Mexican settlement” containing sixty-three families.<sup>82</sup> Although authorities claimed that supervision of the entire household helped to contain disease, the primary benefits were economic: the county saved \$10,000 a year by keeping patients at home rather than sending them to Olive View.<sup>83</sup> Thompson was a strong proponent of the colony, urging that similar projects “be encouraged in all of the counties with a large Mexican population.”<sup>84</sup>

Economic concerns also justified the growing use of quarantine for Mexicans with tuberculosis. In January 1932 A. C. Price, the assistant superintendent of charities, asked Everett Mattoon, the county counsel, for authority to use the quarantine law to remove a Mexican man from the house he shared with his mother and his six children; Mattoon ruled that “the county health officer has the authority to compel forcible hospitalization of people afflicted with tuberculosis.”<sup>85</sup> The number of people compelled to enter institutions under isolation orders grew steadily during the next few years, reaching 149 in 1939.<sup>86</sup> A comment by Thompson suggests that the measure was especially likely to affect Mexicans. After praising the operation of the new law in Los Angeles, she wrote:

I feel that because of the conjected [*sic*] areas in which they [Mexicans] live, and because of their lowered resistance, they become active cases much quicker than other people, and that whenever any person is found to be a spreader of tuberculosis, that the state and local health departments have a moral responsibility to see that the patient is removed from the home and the quarantine made rigid enough to impress the people away from them.<sup>87</sup>

Pomeroy defended the unequal impact of the quarantine in financial terms. Emphasizing the high rate of tuberculosis among Mexicans, he commented: “When it is considered how small a per cent of the expense resulting from this situation is borne by Mexican people directly or by their taxes indirectly, we are justified in our close and sometimes arbitrary supervision of Mexicans with tuberculosis in a communicable state.”<sup>88</sup>

82. “Report of the Tuberculosis Colony in Huntington Park for the Year ending 1933,” file 180.3/264/40.31, LACBS.

83. *Ibid.*

84. “Tuberculosis—Monthly Reports” (n. 28), June 1935.

85. Everett W. Mattoon to John L. Pomeroy, 30 January 1932, file 180.3/254, LACBS.

86. “Annual Report of the Los Angeles County Health Department for 1939–40,” p. 38, file 180.3490, LACBS.

87. “Tuberculosis—Monthly Reports” (n. 28), June 1932.

88. “Annual Report for 1938” (n. 41), p. 63.

## Expulsion

The deportation and repatriation drives of the 1930s had by far the greatest impact on Mexicans with tuberculosis. Although several historians have described those campaigns, the role of tuberculosis has received virtually no attention.<sup>89</sup> I argue here that at least some state and local health officials were deeply implicated in both programs, that concerns about the cost of supporting tubercular Mexicans figured prominently, and that members of that population suffered severely as a result.

The deportation drive began shortly after the Depression descended on Los Angeles. In 1930, Secretary of Labor William Doak stated that the best way to attack unemployment would be to expel “four hundred thousand illegal aliens.”<sup>90</sup> As already noted, the phrase “illegal aliens” had become another name for Mexicans by that date; Doak concentrated his efforts on southern California. He soon received help from Charles P. Visel, the director of the Los Angeles Citizens Committee on the Coordination of Unemployment Relief, a new organization of local civic leaders. In January 1931 Visel devised a plan to frighten Mexican immigrants into leaving the city without formal deportation hearings: He prepared an announcement of an impending deportation campaign which he sent, in his words, to “all newspapers of Los Angeles, including especially the foreign language newspapers.”<sup>91</sup> With Visel’s support, immigration authorities conducted a series of highly publicized raids on Mexican communities. Agents went door-to-door, demanding that residents show proof of legal status and arresting those unable to do so. By 21 February, 225 people had been apprehended; although that group included Chinese, Japanese, and whites, the supervisor of the Bureau of Immigration in Los Angeles wrote that “the Mexican element . . . predominates.”<sup>92</sup> On 26 February, federal agents surrounded the downtown Plaza, detaining four hundred individuals, most of them Mexicans.<sup>93</sup>

Attempts to ferret out illegal immigrants must have been especially terrifying to Mexicans suffering from tuberculosis. By impoverishing

89. See esp. Francisco E. Balderrama and Raymond Rodríguez, *Decade of Betrayal: Mexican Repatriation in the 1930s* (Albuquerque: University of New Mexico Press, 1995); Abraham Hoffman, *Unwanted Mexican Americans in the Great Depression: Repatriation Pressures, 1929–1939* (Tucson: University of Arizona Press, 1974); Sánchez, *Becoming Mexican American* (n. 69).

90. Cited in Sánchez, *Becoming Mexican American* (n. 69), p. 214.

91. Cited in Hoffman, *Unwanted Mexican Americans* (n. 89), p. 44.

92. W. F. Watkins to Robe Carl White, Los Angeles, 21 February 1931, file 55739/674, RG 85, NAW.

93. Hoffman, *Unwanted Mexican Americans* (n. 89), pp. 59–60.

Mexicans and forcing them to apply for relief, the disease also heightened their vulnerability to deportation. Moreover, the Supreme Court interpreted “entry” to mean the “last entry.”<sup>94</sup> As one contemporary observer wrote, “Even after a few hours’ visit in Mexico a health condition which has been present for many years while the person resided in the United States may make him excludable.”<sup>95</sup> Because many Mexican immigrants in Los Angeles frequently traveled back and forth across the border,<sup>96</sup> that interpretation threatened them.

Although we have no way of knowing whether health authorities endorsed the tactics employed by federal agents in Los Angeles, we have seen that other efforts to deport Mexicans enjoyed support from Edythe Tate Thompson. Federal agents traditionally had looked for deportable aliens in public hospitals (along with asylums and jails).<sup>97</sup> In 1930 Thompson wrote: “Efforts have been made to deport Mexicans, or at least care for them only until the immigration authorities could deport them.”<sup>98</sup> Two years later, the California Department of Public Health referred to its “Cooperation with the US Immigration Service”;<sup>99</sup> unfortunately, the Board did not specify the nature of that cooperation.

Some evidence also suggests that just as welfare officials used the threat of deportation to encourage voluntary departure, so health authorities used that threat to compel compliance with medical regimes. According to an M.A. thesis at the University of Southern California School of Social Work in 1939, the widespread fear of deportation proceedings helped to “force” recalcitrant Mexicans to accept institutional care.<sup>100</sup> In 1934, Thompson complained about a Mexican farm couple who were U.S. citizens. After noting the woman’s refusal both to believe that her child had died from tuberculosis and to submit to an

94. Reuben Oppenheimer, *The Administration of the Deportation Laws of the United States*, Report to the National Commission on Law Observance and Enforcement (Washington, D.C.: U.S. Government Printing Office, 1931), p. 35.

95. Carrie Belle H. MacCarthy, “A Survey of the Mexican Hardship Cases Active in the Los Angeles County Department of Charities, Los Angeles, California” (M.A. thesis, Social Work, University of Southern California, 1939), p. 66, Doheny Library, University of Southern California.

96. Sánchez, *Becoming Mexican American* (n. 69), p. 41.

97. Ngai, “The Strange Career” (n. 53).

98. Edythe Tate Thompson, “Report of the Bureau of Tuberculosis,” in *Thirty-first Biennial Report of the Department of Public Health of California for the Fiscal Years from July 1, 1928, to June 30, 1930* (Sacramento: California State Printing Office, 1930), p. 128.

99. *Thirty-second Biennial Report of the Department of Public Health of California for the Fiscal Years from July 1, 1930 to June 30, 1932* (Sacramento: California State Printing Office, 1932), p. 132.

100. MacCarthy, “Survey” (n. 95), p. 83.

examination herself, Thompson concluded: "There is nothing as difficult to handle as an American-born Mexican. . . . They can and do defy everything and everybody."<sup>101</sup>

But the deportation campaign may well have also undermined public health goals. Reporting on the "first roundups of aliens," Supervisor W. F. Watkins of the Bureau of Immigration noted that many had gone "into hiding" and that they were "generally well informed as to the provisions of the immigration law and the conditions under which they may or may not be deported."<sup>102</sup> We can well imagine that long after the raids ceased many Mexicans were unwilling to report symptoms of tuberculosis, undergo diagnostic examinations, or attend clinics. The executive secretary of the Los Angeles Tuberculosis and Health Association wrote in April 1934: "Patients who are not yet citizens of the United States and who have contracted tuberculosis often seek information regarding rules and regulations relative to deportation which might affect their care."<sup>103</sup> A social worker later recalled that breadwinners were extremely reluctant to accept institutionalization, knowing that their departure would force other members of the family to rely on public assistance and would thus increase the risk of deportation.<sup>104</sup> Mexicans must have been especially anxious to avoid home visits, which could reveal family members who wished to remain hidden and could uncover such conditions as coresidence by unmarried couples, which might lead to deportation on grounds of moral turpitude.<sup>105</sup>

Repatriation<sup>106</sup> differed from deportation in three ways: First, returnees left voluntarily rather than after formal proceedings. (Several historians note, however, that Mexicans on relief frequently felt enormous pressure to depart.)<sup>107</sup> Second, repatriation affected far more individuals. And third, it was organized by local rather than federal officials. In

101. "Tuberculosis—Monthly Reports" (n. 28), 2 May 1934.

102. W. F. Watkins to Robe Carl White, Los Angeles, 8 and 21 February 1931, file 5738/674, RG 85, NAW.

103. Los Angeles Tuberculosis and Health Association, Executive Secretary's Report, April 1934, p. 4, Clements Papers, Special Collections, Young Research Library, UCLA, Los Angeles, Calif.

104. Interview with Frances Feldman, University of Southern California, Los Angeles, December 2000.

105. See Oppenheimer, *Administration* (n. 94), pp. 31, 100.

106. As many historians have noted, the term is a misnomer because many people who were "returned" to Mexico had been born in the United States.

107. Balderrama and Rodríguez, *Decade of Betrayal* (n. 89), p. 99; Camille Guerin-Gonzales, *Mexican Workers and American Dreams: Immigration, Repatriation, and California Farm Labor, 1900–1930* (New Brunswick, N.J.: Rutgers University Press, 1994), p. 84; Hoffman, *Unwanted Mexican Americans* (n. 89), p. 91.

January 1931, the Los Angeles County Department of Charities asked the Board of Supervisors for funds to pay the rail fares of Mexicans to the border. The first repatriation train departed on 23 March 1931 with 350 people on board.<sup>108</sup> By the end of 1933 the county had sponsored fifteen trains, carrying a total of 12,786 Mexicans.<sup>109</sup>

Because the campaign targeted relief recipients, families visited by tuberculosis must have constituted a high proportion of the returnees. The Cordova family's experience demonstrates one way tuberculosis could lead to repatriation: Antanacio Cordova entered the United States in 1912 and supported his wife and five children by working as an olive picker. Soon after his death from tuberculosis in 1922, the family applied for relief. They relied on such assistance off and on until 1932, when they returned to Mexico on a repatriation train.<sup>110</sup>

The administrative structure in Los Angeles facilitated the expansion of the notion of "public charge" to include the use of medical care. The Department of Charities, the agency directing the repatriation drive, was responsible not just for the Bureau of Indigent Relief but also for Los Angeles General Hospital and Olive View Sanatorium; after 1932, its jurisdiction expanded to include most outpatient care delivered by the county. Department officials justified repatriation by pointing not just to the relief directed to Mexicans, but also to the high cost of the health-care services they received. On 29 January 1934 Rex Thomson, the superintendent of the department, wrote to Alejandro V. Martinez, the Mexican consul in Los Angeles, requesting his support for the repatriation campaign: "You will readily perceive that the savings to the taxpayers due to the success of this repatriation has been tremendous"; those savings included not only the cost of the relief that would have been spent on the repatriates but also "the immense outstanding costs in the way of hospitalization, clinical and medical attention, and education facilities which this community is obligated to provide."<sup>111</sup> Fourteen months later, Thomson urged the Board to endorse a resettlement plan in Mexico to encourage more immigrants to return, "thereby ultimately producing a tremendous savings, not only in the cost of relief . . . but also reducing materially the costs of relief afforded in our institutions to such indigent aliens and effecting a savings in the costs of other Governmental services afforded to them such

108. Hoffman, *Unwanted Mexican Americans* (n. 89), p. 87.

109. J. H. Winslow to Rex Thomson, Los Angeles, 26 January 1934, file 55853/737, RG 85, NAW.

110. MacCarthy, "Survey" (n. 95), p. 57.

111. Rex Thomson to Alejandro V. Martinez, Los Angeles, 29 January 1934, file 55853/737, RG 85, NAW.

as general health, educational, etc.”<sup>112</sup> (As we have seen, tuberculosis traditionally had represented a large proportion of “general health” costs.)

No accounts survive of conversations between Department of Charities staff and individual Mexican clients. Two cases that came to the attention of the Board of Supervisors, however, demonstrate the determination of staff to rid the county of clients with large medical expenses. In both, the department requested funds to return the families to Mexico by car rather than on the organized train trips. The first, occurring in August 1930, involved a woman and her six children. According to the letter from a department social worker, the family received \$67.50 in county aid each month. In addition, “The children present numerous health problems which require costly medical care”; federal immigration authorities had refused the department’s request to deport the family, but promised that if the family “can be taken to Tiajuana the immigration officer will prevent their return.”<sup>113</sup> The second case, three years later, involved a couple with six children. The superintendent of the Bureau of Welfare wrote that “the man and woman are both ill and represent an expensive case.”<sup>114</sup>

To some extent, the repatriation drive represented a continuation of the expulsion policy inaugurated by the Department of Charities in 1909. The pace of removals accelerated during the 1930s, when destitute migrants from other states poured into Los Angeles; as Edythe Tate Thompson commented in 1936, officials tried to get those with tuberculosis out of the state “as quickly as possible.”<sup>115</sup> But there were critical differences between the two programs. County officials pressured interstate migrants to return home only before they established residence; Mexicans, however, were repatriated regardless of the length of their residence in the county or state. The repatriation program thus clearly demonstrated that Mexicans never could consider Los Angeles home.

Moreover, by the 1930s the Department of Charities had established a policy of returning sick interstate migrants only if they could find medical care in their own communities. Although the department occasionally transported people in the absence of guarantees,<sup>116</sup> staff contacted

112. Rex Thomson to Los Angeles County Board of Supervisors, 21 March 1935, file 40.31/340.46, LACBS.

113. Winifred Ryle to A. C. Price, Los Angeles, 1 August 1930, file 40.31/297, LACBS.

114. A. C. Price to Board of Supervisors, Los Angeles, 20 July 1938, file 40.31/858, LACBS.

115. “Tuberculosis—Monthly Reports” (n. 28), March 1936.

116. See Rex Thomson to Los Angeles County Board of Supervisors, 30 September 1935, file 40.31/1366; 7 October 1935, file 40.31/1386; 25 March 1936, file 40.31/1425, LACBS.

local authorities and pressured them to promise to provide care. But the department was well aware that no medical assistance awaited the vast of majority of Mexican repatriates. In an unusual display of solicitude for Mexicans, Edythe Tate Thompson referred in March 1934 to “the great numbers of tuberculous repatriates that were being left in various Mexican States without provision for care.”<sup>117</sup>

The repatriation program also must have affected the health status of those left behind. As George Sánchez demonstrates, the program devastated Mexican communities in Los Angeles.<sup>118</sup> In an evaluation of the Huntington Park Mexican Colony, Violet Blanche Goldberg, a social work graduate student, discussed the case of a woman who returned home two months after entering Olive View Sanatorium: in her absence, Goldberg wrote, “the cousin’s family, also living in the house, had been repatriated through the efforts of the Department of Charities, and the home conditions were much improved.”<sup>119</sup> But if the relatives’ departure reduced overcrowding, it may also have removed the sources of care on which the woman depended. The loss of neighbors and friends must often have destroyed the social networks that are essential to healing.

On 25 May 1937 Rex Thomson wrote to the Board of Supervisors, requesting permission to hire five to ten social workers who “possess the ability to speak Spanish of extreme fluency” and who could encourage indigent Mexicans to accept repatriation regardless of whether they were “employable or non-employable.”<sup>120</sup> By that date, indigent people deemed “employable” had been transferred to the rolls of the State Relief Administration or the federal Works Progress Administration. The County Department of Charities thus provided relief primarily to “unemployable” people, most of whom were sick or disabled; that department did, however, remain responsible for providing health care to all indigents, regardless of the source of their financial assistance.<sup>121</sup> The bulk of Thomson’s letter consisted of an account of the “material and medical relief” furnished by the county. For the first time since the 1925 *Statistical Study*, specific figures were attached to the medical expenses associated with Mexicans: the county spent \$46,058 a month on material relief to

117. “Tuberculosis—Monthly Reports” (n. 28), 31 March 1934.

118. Sánchez, *Becoming Mexican American* (n. 69), pp. 209–26.

119. Violet Blanche Goldberg, “A Study of the Home Treatment of Tuberculosis Cases with the Details of a Colony Plan in Los Angeles County and a Study of a Family Group of Ninety-Nine” (M.A. thesis, Social Work, University of Southern California, 1939), p. 47, Doheny Library, University of Southern California.

120. Rex Thomson to Los Angeles County Board of Supervisors, 25 May 1937, file 40.31/340.47, LACBS.

121. *Ibid.*



“Mexican aliens,” and another 74 percent of that amount on medical care (\$30,395 for institutional care and \$3,630 for outpatient care).<sup>122</sup>

Thomson attempted to reduce that burden in two ways. In 1938 the Department of Charities transported four infirm people to Mexico in February, two in May, four in August, and seven in October.<sup>123</sup> Abraham Hoffman writes that the repatriation program had “declined to the point where repatriates for the most part were . . . blind, tubercular, paralyzed, or were minor children or the aged.”<sup>124</sup> The numbers involved certainly paled in comparison with those in earlier years, when trainloads of repatriates departed from Los Angeles. But these final trips also highlight a concern with the high cost of health care that had animated the program since its inception.

Tuberculosis was the diagnosis of approximately half the passengers on the 1938 trips.<sup>125</sup> That disease also was central to Thomson’s second effort to reduce the cost of caring for Mexicans. At his behest, Gordon L. McDonough, a member of the Los Angeles County Board of Supervisors, traveled to Mexico in October 1938 to attempt to convince government officials to accept the return of Mexicans with tuberculosis. One problem was the paucity of available care. McDonough discovered that “the only tubercular hospital in Mexico is located at Talalpam, Huipulco. Dr. Donato Alarcon is director and the capacity is 180 beds,” but he added that access was not the concern of Los Angeles County: “The question of whether this institution is inadequate or not is one for the Mexican government to determine.”<sup>126</sup> That statement represented a radical departure from the policy vis-à-vis interstate migrants.

A much thornier issue revolved around the timing and place of infection. Describing his conversation with Ignacio García Tellez, the Mexican secretary of the Interior, McDonough wrote: “Concerning the tubercular cases, the question . . . arose as to whether these people had contracted tuberculosis in the United States or whether they were permitted to enter the United States with tuberculosis, after having passed the United States Health Service Examination.”<sup>127</sup> McDonough claimed to find some support for his assertion that Mexicans imported tuberculosis

122. Ibid. Thomson noted, however, that the figures he provided were only approximations.

123. Rex Thomson to Los Angeles County Board of Supervisors, 10 February, 16 May, 9 August, 18 October 1938, file 40.43/340, LACBS.

124. Hoffman, *Unwanted Mexican Americans* (n. 89), p. 159.

125. File 40.31/340, LACBS.

126. Gordon L. McDonough to Los Angeles County Board of Supervisors, 21 November 1938, p. 3, file 40.31/340, LACBS.

127. Ibid., p. 2.

in an interview with Dr. Walter Garnett, the United States Public Health Service official at El Paso responsible for administering medical examinations to people seeking visas for stays longer than 180 days. According to McDonough, Garnett stated that he “was allowed only \$100.00 a month by the United States Government which did not provide sufficient funds for a detailed examination of people who may be afflicted with tubercular, venereal diseases or other contagious diseases.”<sup>128</sup> Mexicans seeking permission to enter for shorter periods rarely received medical inspection.<sup>129</sup> The laxity of border control, of course, did not prove either that Mexico had high levels of tuberculosis, or that many Mexicans suffered from the disease when they entered the United States. Indeed, McDonough’s arguments failed to convince the Mexican government, which insisted that its nationals contracted tuberculosis in the United States.<sup>130</sup>

Shortly after receiving McDonough’s report, the Los Angeles County Board of Supervisors directed J. H. O’Connor, the county counsel, to determine whether responsibility for the care of “Mexican aliens” with tuberculosis rested with Mexico or Los Angeles.<sup>131</sup> The issue rapidly became moot, however, in the face of the continued refusal of the Mexican government to accept the argument that it had an obligation to render such care.<sup>132</sup> On 6 December, the Board of Supervisors rescinded its order to O’Connor.<sup>133</sup> Soon afterward, all efforts to continue the repatriation program ended.

As a result of both deportation and repatriation, the Mexican population of Los Angeles declined by a third.<sup>134</sup> In 1932, the State Health Department wrote: “The exodus of thousands of Mexicans from this State has reduced both our clinic and hospital population with reference to this group.”<sup>135</sup> The silence about the effect of these campaigns on the health status of Mexicans, both in Los Angeles and at home, was striking.

## Conclusion

On 15 January 1929, W. H. Holland, the superintendent of charities of Los Angeles County, wrote to the Board of Supervisors about William

128. *Ibid.*

129. *Ibid.*

130. See Balderrama and Rodríguez, *Decade of Betrayal* (n. 89), p. 90.

131. L. E. Lampton to J. H. O’Connor, 6 December 1938, file 30.41/340, LACBS.

132. See Balderrama and Rodríguez, *Decade of Betrayal* (n. 89), p. 90.

133. Lampton to O’Connor, 6 December 1938 (n. 131).

134. Sánchez, *Becoming Mexican American* (n. 69), p. 210.

135. *Thirty-second Biennial Report of the Department of Public Health* (n. 99), p. 132.

Anderson, a white carpenter who had lived in Central America for twenty years. "Since this man came here from a foreign country and became ill in this country," Holland argued, "I would respectfully recommend that the residence requirements be waived and he be allowed to receive aid from Los Angeles County Funds" for sanatorium care.<sup>136</sup> Eight days later, the Board approved the request.<sup>137</sup>

The response to Mexicans with tuberculosis could hardly have been more different. Edythe Tate Thompson, the director of the California Bureau of Tuberculosis, assumed that Mexicans brought the disease with them. Even many officials who believed otherwise agreed that innate biological deficiencies rendered Mexicans especially vulnerable to tuberculosis. Rather than assuming a special obligation for Mexicans and easing their admission to institutions, both state and local authorities constructed barriers to their treatment. By the early 1930s, a disproportionate number of Mexicans who entered Olive View did so under isolation orders. And health officials used the high cost of caring for tubercular Mexicans as a rationale for participating, first, in efforts to restrict immigration, and then in the deportation and repatriation drives.

Not all tubercular whites, of course, received Anderson's favored treatment. Indeed, the association of Mexicans with tuberculosis may have had such disastrous consequences for them partly because health officials exhibited hostility toward all sufferers with advanced disease and few financial resources. The exclusionary strategies adopted in response to very sick and very poor whites at the turn of the century laid the basis for those directed toward Mexicans between 1925 and 1940. Yet tuberculosis policy in Los Angeles also had an important racial dimension. The differences in the treatment of tubercular Mexicans and whites both reflected and reinforced the increasingly widespread notion that all Mexicans were "illegal aliens" who had no entitlement to social provision and did not belong in Los Angeles.

136. W. H. Holland to Los Angeles County Board of Supervisors, 15 January 1929, file 40.20/104, LACBS.

137. L. E. Lampton to W. H. Holland, 23 January 1929, *ibid.*