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Rising to the Surface: Disasters and Racial Health Disparities in American History

By Marian Moser Jones*

Disasters are fundamentally social and cultural phenomena.¹ Often, the solutions to disaster preparedness [and] response do not just involve technology.² Of course we need warning systems, and of course, it is great to know that a hurricane is coming two days ahead of time [so] we can get out of the way.³ But fundamentally, we have to look at our society and inequalities in our society, and cultural differences in order to address how to get human beings out of harm's way and to mitigate disasters.⁴ So before I begin, I would like to warn you about the history of disasters and health disparities in the United States. This history is not for the faint of heart. You are law students, so you have probably crossed that bridge already in torts classes and other classes. But this not for those who would rather avoid discussing the unseemly and uncomfortable aspects of our shared past as Americans.

And neither is it for those [who] believe that history should be told exclusively by survivors. In this particular corner of American history, the history of disasters, the anonymous dead have possessed the uncanny ability to rise to the surface and to help the living speak truth to power. The 1927 Mississippi flood, an archetypal example of health disparities in disaster, presents a case in point. Two months after the flood began, in June

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1. See Anthony Oliver-Smith, "What is a Disaster?: Anthological Perspectives on a Persistent Question," in *THE ANGRY EARTH* (Anthony Oliver-Smith & Susana Hoffman eds., 1999) (describing different approaches and the difficulties involved in defining "disasters").

2. See James R. Elliot & Jeremy Pais, *Race, Class, and Hurricane Katrina: Social Differences in Human Responses to Disaster*, 35 *SOC. SCI. RES.*, no. 2, 318 (2006) ("The basic idea would be to buttress top-down warnings with ongoing planning and preparedness orchestrated through trusted local associations, similar to how school teachers help to educate and evacuate their own groups of students when an ominous but distant bell sounds and the entire school must evacuate.").

3. See Amy L. Fairchild et. al., *The Challenge of Mandatory Evacuation: Providing For and Deciding For*, 25 *HEALTH AFF.*, no. 4, 958 (describing the role of government and public health officials in ordering mandatory evaluations in the face of impending disaster).

4. See Elliot & Pais, *supra* note 2, at 317 (analyzing the correlation between race, class, and the adequacy of disaster relief in the context of Hurricane Katrina).

1927, a correspondent for the *Chicago Defender*, which was the leading African American newspaper in the country, reported that the health officer in Greenville, Mississippi, had given typhoid inoculations “earlier in the week in his office to whites only.”⁵ Typhoid inoculations were [considered] a key protective measure against infections from this deadly water-borne bacillus, this microbe that tends to flourish in standing pools of water that accompany floods and hurricanes.⁶ But he had limited his vaccinations to whites.⁷ “Members of our race are still suffering from measles, mumps, and typhoid. ‘They received very little treatment, and those who die are cut open, filled with sand, and then tossed into the Mississippi River,’ the correspondent wrote.”⁸ Now as this painful example illustrates, disaster-related disparities have long plagued the United States, even if the field of health disparities, named as such, is a relatively new area of inquiry and policy. In this talk I will briefly outline the short history of health disparities as a field, and discuss the connection between health disparities and disasters and then review several historical examples of health disparities in 20th century U.S. disasters and their lessons for current policy.

“Health disparities,” as an identified field of federally-sponsored public health research, can be dated back only to January 1984.⁹ That is

5. See MARIAN MOSER JONES, *THE AMERICAN RED CROSS: FROM CLARA BARTON TO THE NEW DEAL* 216 (2013) (describing the state of black Mississippians after the Great Mississippi Flood of 1927); Mary E. Stovall, *The ‘Chicago Defender’ in the Progressive Era*, 83 ILL. HIST. J. 159 (1990). See also CHARLES A. SIMMONS, *THE AFRICAN AMERICAN PRESS: A HISTORY OF NEWS COVERAGE DURING NATIONAL CRISES, WITH SPECIAL REFERENCE TO FOUR BLACK NEWSPAPERS 1827-1965*, 25–42 (1998).

6. Typhoid inoculations were used widely in the early to mid-twentieth century to protect flood and hurricane victims, but were by the late 1970s deemed to be of limited usefulness, as they do not confer immunity immediately, and the danger of infection has usually passed by the time they are effective. See *Morbidity and Mortality Weekly Report*, U.S. CENTERS FOR DISEASE CONTROL, Dec. 17, 1994, Vol. 43, No. RR-14 (describing the importance of typhoid inoculations for residents of flood areas). But see Ira V. Hiscock, *Public Health Work in the Flood Area*, 17 AM. J. OF PUB. HEALTH 810–13 (1927) (describing widespread typhoid inoculations during the 1927 flood). See also Melvina F. Palmer, *Health Activities to Combat Flood Damage*, 71 PUB. HEALTH REP. 822 (1956), (describing the over 40,000 typhoid inoculations resulting from the 1956 Pennsylvania flood).

7. See Jones, *supra* note 5, at 216 (“In early June, *The Defender* reported that the health officer in Greenville, Mississippi, gave typhoid inoculations earlier in the week at his office to whites only.”).

8. *Id.*

9. See MARGARET M. HECKLER, U.S. DEP’T OF HEALTH AND HUMAN SERVS.: REPORT OF THE SECRETARY’S TASK FORCE ON BLACK & MINORITY HEALTH, at ix (Washington: GPO, 1985) [hereinafter “Report of the Secretary’s Task Force”] available at <http://minorityhealth.hhs.gov/assets/pdf/checked/1/ANDERSON.pdf> (“a continuing disparity . . .”, “an affront to . . .”).

when President Ronald Reagan's Secretary of Human Services, Margaret Heckler, in her annual report card on the health status of Americans, called attention to what she later called "a continuing disparity in the burden of death and illness experienced by blacks and other minority Americans as compared with our nation's population as whole."¹⁰ Inveighing against this disparity as "an affront to both our ideals and to the ongoing genius of American medicine," Heckler went on to organize a task force at the National Institutes of Health on black and minority health.¹¹ This task force in [its] 1985 report painstakingly documented the [nearly] 60,000 yearly excess deaths among black and other racial minority populations in comparison to white Americans.¹² As Vanessa Northington Gamble and Deborah Stone have noted, this report catapulted minority health issues onto the nation's research and health policy agendas.¹³ The Department of Health and Human Services created an Office of Minority Health at HHS and NIH—the National Institutes of Health—an Office of Research [on] Minority Health. In 2010, 25 years later, this became the National Institute on Minority Health and Health Disparities.¹⁴ In the meantime, the federal government and most states identified the elimination of health disparities between whites and racial minorities, along with socioeconomic health disparities as key public health goals.¹⁵

But it is important to note that long before Heckler's call to arms, researchers and health officials were documenting and striving to address racial gaps in health access and health outcomes. In his 1906 study, *The*

10. *Id.*

11. *Id.*

12. *Id.* at 5.

13. Vanessa Northington Gamble & Deborah Stone, *U.S. Policy on Health Inequities: The Interplay of Politics and Research*, 31 J. OF HEALTH POL., POL'Y AND LAW 105 (2006) (synthesizing the relationship between scientific research and government action in addressing health inequalities in America).

14. NAT'L INST. ON MINORITY HEALTH AND HEALTH DISPARITIES: *History*, NAT'L INST. OF HEALTH, <http://www.nih.gov/about/almanac/organization/NIMHD.htm> (last visited Feb. 13, 2013) (describing the mission and history of National Institute on Minority Health and Health Disparities) (on file with the WASH. & LEE J. CIVIL RTS. & SOC. JUST.). *See also* OFFICE OF MINORITY HEALTH, U.S. DEP'T OF HEALTH AND HUMAN SERVS., *About OMH*, <http://minorityhealth.hhs.gov/templates/browse.aspx?Lvl=1&lvlID=7> (last visited Feb. 13, 2013) (detailing the purpose and working of OMH) (on file with the WASH. & LEE J. CIVIL RTS. & SOC. JUST.).

15. *See* Gamble & Stone, *supra* note 13, at 105 (citing JOHN E. McDONOUGH ET AL., A STATE POLICY AGENDA TO ELIMINATE RACIAL AND ETHNIC HEALTH DISPARITIES 11 (The Commonwealth Fund 2004) (describing the disparities between minority health and health care, and the health and health care of whites)).

Health and Physique of the Negro American, sociologist W.E.B. Du Bois used federal census reports and vital statistics, as well as life insurance data, to identify the disparities in health status between black and white Americans, even if he did not use the word “disparities.”¹⁶ Now unlike the white statistician Frederick Hoffman, who argued that these differences resulted from the inherent genetic inferiority of African Americans (this was a widely-held assumption), Du Bois implicated environmental causes.¹⁷ By environmental causes, I mean the lack of sanitation in segregated neighborhoods where black Americans were forced to live, along with the lack of educational and economic opportunity faced by African Americans, as the fundamental reasons for this disparity. Now Du Bois was interesting—he did not stop at research, but he actively advocated for the elimination of the underlying limits on educational and economic opportunities that he believed led to these disparities.¹⁸

Du Bois’ expansive approach can inspire us to look at contemporary health disparities with a fresh perspective. Most recent health disparities research has been funded by federal and state governments, and as such it reflects the focus and the constraints of the federal health disparities research and policy agenda. Now this agenda was shaped by the 1985 task force report, which identified six major causes of excess mortality among African Americans: cancer; cardiovascular disease and stroke; chemical dependency measured by cirrhosis; diabetes; homicide and accidents; and infant mortality.¹⁹ Since then, health disparities research has mainly focused on eliminating or reducing disparities related to these six diseases. Now this makes sense, as focusing on concrete, achievable goals will more likely lead to progress than a more diffused approach. But when we think about disaster, most disaster-related health disparities do not easily fall into these six categories; even though disasters do increase rates of accidents and may increase rates of chronic disease. Disasters involve multiple

16. See W.E.B. DU BOIS, *THE HEALTH AND PHYSIQUE OF THE NEGRO AMERICAN: A STUDY MADE UNDER THE DIRECTION OF ATLANTA UNIVERSITY BY THE ELEVENTH ATLANTA CONFERENCE*, Preface, 20–21 (1906) (discussing the anthropological evidence countering inherent inferiority of “negroes”) (quoted in Stone & Gamble, *supra* note 6, at 93).

17. Compare FREDERICK L. HOFFMAN, *RACE TRAITS AND TENDENCIES OF THE AMERICAN NEGRO* (1896) (arguing that disparities in health statuses between whites and African Americans were a result of African Americans’ genetic inferiority), with W.E.B. DU BOIS, *THE HEALTH AND PHYSIQUE OF THE NEGRO AMERICAN: A STUDY MADE UNDER THE DIRECTION OF ATLANTA UNIVERSITY BY THE ELEVENTH ATLANTA CONFERENCE* (1906) (suggesting that health disparities are caused, in part, by environmental factors).

18. See DAVID LEVERING LEWIS, *W.E.B. DU BOIS: A BIOGRAPHY* 1–4 (2009).

19. See Report of the Secretary’s Taskforce, *supra* note 9, at 3–5.

moving parts: weather, technology, geology, prior urban settlement patterns, transportation networks, [and] communication networks, to name a few. And unlike diabetes, heart disease, accidents, or other similar diseases, disasters cannot be tied easily to bodies and behaviors. In fact, the word “disaster” itself is a fungible and fuzzy construct. Geographer Ben Wisner’s definition of disaster, as [the interaction of] a technological or natural hazard and a vulnerable human population has been increasingly adopted by scientists.²⁰ But even this definition is up for debate, although I generally espouse this definition.

Now as a result of this complexity, disaster-related health disparities remain little studied and little understood. In the 21st century, such disparities risk becoming obscured by the monstrous shadow of Hurricane Katrina. Indeed, Katrina and its aftermath made it clear that structural racism and poverty can increase a population’s vulnerability to the hazards of weather.²¹ But little research has explored disaster-related health disparities outside of the specific context of this hurricane—and I do not mean to say this [storm] is not very important to study. But if we only study Katrina, we risk falling into the trap of dismissing disaster-related health disparities as originating out of the unique geographic, cultural, and political context of New Orleans, 2005. And this would be a dangerous error, because history, even the recent history of the United States in the 20th century, tells us that disaster-related racial health disparities have recurred across divergent temporal and social contexts.

The 1906 San Francisco earthquake, which led to a fire that burned down a large swath of that city, including the city’s Chinatown, left the nation’s largest Asian population homeless.²² Forced into a single, segregated refugee camp, denied financial assistance from the Red Cross and other charitable groups, Chinese San Franciscans, together with the small Japanese San Francisco population, were targeted by xenophobic white thugs with violent attacks.²³ Members of the armed forces who

20. See BEN WISNER ET. AL., *AT RISK: NATURAL HAZARDS, PEOPLE’S VULNERABILITY AND DISASTERS*, 4–5 (2nd ed. 2004) (proffering a definition of the term disaster).

21. See KEITH WAILOO ET AL., *KATRINA’S IMPRINT: RACE AND VULNERABILITY IN AMERICA* 1–8 (2010); Chester Hartman & Gregory D. Squires, *Pre-Katrina: Post-Katrina*, in *THERE IS NO SUCH THING AS A NATURAL DISASTER: RACE, CLASS, AND HURRICANE KATRINA* 1–11 (Hartman & Squires, eds., 2006) (noting the correlation between race and suffering harm from dangerous weather).

22. See YONG CHEN, *CHINESE SAN FRANCISCO, 1850–1943: A TRANS-PACIFIC COMMUNITY* 3 (2000) (describing America’s largest Asian population).

23. See JONES, *supra* note 5, at chap. 7 (describing the attacks). See also PHILIP L. FRADKIN, *THE GREAT EARTHQUAKE AND FIRESTORMS OF 1906: HOW SAN FRANCISCO NEARLY*

policed the area following the earthquake in an undeclared regime of martial law, were ordered to shoot looters on sight. And evidence from newspapers and other sources indicates that a disproportionate number of those shot and killed, no questions asked, were Asian San Franciscans.²⁴ After the disaster, when Chinatown was rebuilt, structures were erected quickly, without regard to considerations of safety and crowding. And here is where you get to law, because zoning laws were very lax and not enforced. The residents of Chinatown were barred from living elsewhere in the city and were forced to live in a cramped labyrinth of rickety, dangerous housing. As a result, rates of tuberculosis and other infectious diseases, which were fostered by crowded, unsanitary conditions, subsequently increased in this area. In the years following the earthquake, although rates of TB among all San Franciscans increased as crowded tenements were built to house the city's white working class citizens as well, rates of TB among Chinese San Franciscans reached three times that of the city's population as a whole and four times the national average.^{25,26}

We can take another case, twenty years later, on the opposite coast. When a major hurricane ran over Miami [in September 1926], most of the city's diverse, black, Caribbean and African American communities were protected from instant death, largely because of the city's strict regime of racial segregation, which restricted ownership of oceanfront property and enjoyment of its beaches to whites. Now the storm rolled over the city at night, when few black Miamians were working at these racially restricted [residential] areas.²⁷ So you see here, what seems to appear is a reverse pattern of racial disparity and mortality. But this pattern was soon over-

DESTROYED ITSELF, 164–166, 182 (2005); Marshall Everett, *Chinese Give Generously*, in *THE COMPLETE STORY OF THE SAN FRANCISCO EARTHQUAKE 1906* (1906).

24. See PHILIP L. FRADKIN, *THE GREAT EARTHQUAKE AND FIRESTORMS OF 1906: HOW SAN FRANCISCO NEARLY DESTROYED ITSELF* 296–303 (2005) (documenting the hostilities against Asian San Franciscans through personal stories and newspaper articles).

25. See SUSAN CRADDOCK, *CITY OF PLAGUES: DISEASE, POVERTY AND DEVIANCE IN SAN FRANCISCO* 38–42 (2000) (discussing the overcrowded tenements and result of increased tuberculosis amongst minorities because of the living conditions).

26. See *id.* at 202–04 (citing a report from the San Francisco Tuberculosis Association in 1915).

27. See Paul S. George, *Colored Town: Miami's Black Community, 1896–1930*, 56 *THE FLORIDA HIST. QUARTERLY* 432, 435 (1978) (“Residential segregation, the cornerstone of racial separation, was from the beginning the rule in Miami.”); see also NATHAN DANIEL BEAU CONNOLLY, *BY EMINENT DOMAIN: RACE AND CAPITAL IN THE BUILDING OF AN AMERICAN SOUTH FLORIDA* 40–43 (UMI Dissertation Publishing 2008) (recounting the story of Wilhelmina Jennings, a Bahamian-American who was ordered to clean up destruction from the 1926 hurricane).

turned when white National Guardsmen began rounding up black men and women to do cleanup work, exposing them to typhoid and malaria from standing water, as well as the hazards of exposed nails, splintered wood, and snakes that slithered through the flooded neighborhoods.²⁸ Other black Miamians who had lost their homes in what they called “The Big Blow,”²⁹ were forced to live in the single refugee camp for African Americans, which was located in the unsanitary stables of the local racetrack, which had also been damaged in the hurricane. They were given limited aid by the American Red Cross.³⁰

Perhaps the most egregious example of racial disparities in a disaster during this period, however, occurred during the aforementioned 1927 Mississippi Flood. By early April of 1927, the flood had turned the Delta region of Arkansas, Louisiana, and Mississippi into what a *National Geographic* reporter described as “a vast sheet of water . . . about 1,050 miles long and in some places, over 50 miles in width.”³¹ The flood drowned hundreds of people while destroying the region’s crops and livestock. Local white planters, the owners of plantations, enlisted black men, often by force and sometimes at gunpoint, to work long shifts sand-bagging the levees and building out the levees and, as a result, exposing them to [a] higher risk of drowning when the flood overtopped the levees. And this happened on numerous occasions.³² Now for the 325,000 people whose homes were flooded, the American Red Cross set up racially-segregated tent camps in keeping with the local custom and national

28. See *id.* (using Wilhelmina Jennings’ story about the pressure for blacks to do the hard labor in the clean-up).

29. See *The Hurricane of 1926*, PBS, available at <http://www.pbs.org/wgbh/aex/miami/peopleevents/pande07.html> (giving history on the 1926 hurricane in Miami and referring to it as “The Big Blow”).

30. See MARION MOSER JONES, *CONFRONTING CALAMITY: THE AMERICAN RED CROSS AND THE POLITICS OF DISASTER RELIEF, 1881–1939*, 516–18 (UMI Dissertation Publishing 2008) (discussing the difficulties faced by black families as a result of racial segregation policies).

31. Frederick Simplish, *The Great Mississippi Flood of 1927*, *NAT’L GEOGRAPHIC MAG.*, Sept. 1927, at 272.

32. See Robyn Spencer, *Contested Terrain: The Mississippi Flood of 1927 and the Struggle to Control Black Labor*, 79 *J. OF NEGRO HIST.* 170–78 (1994), available at <http://www.jstor.org/stable/pdfplus/2717627.pdf?acceptTC=true> (discussing the precarious situation whereby blacks were forced to continue working for whites and efforts were made to prevent other opportunities from being presented to black workers); see also PETE DANIEL, *DEEP’N AS IT COME: THE 1927 MISSISSIPPI RIVER FLOOD* 68–72 (2d ed., Univ. of Ark. Fayetteville Press 1996) (quoting a worker remembering armed guards along the levee and the dangers of getting around).

practice.³³ Most African Americans in the area were just tenant farmers in the oppressive sharecropping system, which required them to rent their land, food, and supplies, often at high rates of interest charged by the planters who owned the land, and then pay back this with a portion of their crops. This system caused most sharecroppers, black and white, to slip into a cycle of indebtedness from which they could not escape except by fleeing the area. And the planters often prevented the sharecroppers from fleeing by force and intimidation.³⁴ Many sharecroppers lived in flimsy cabins along the rich soil of the flood plain, while planters and white merchants who serviced the plantation economy lived in solid, multiple-story homes on high ground. So during the flood, these more affluent whites could simply decamp to the second story or attic of their home until the flood receded from their first floor. Most black sharecroppers had nowhere to go except for the refugee camps established by the American Red Cross.³⁵ The Red Cross, which was a quasi-governmental organization that followed the American governmental tradition of privileging local autonomy over centralized national control, largely allowed the white Southerners to run these camps.³⁶ Not surprisingly, the conditions of the camps for African American flood sufferers were squalid, and conditions at the white camps, which were less crowded, were better.³⁷ A correspondent from the *Chicago Defender* who visited the black camps wrote, that “epidemics of measles, whooping cough, mumps, scarlet fever, and chicken pox were raging in these camps.”³⁸ The African American camps were also patrolled by white National Guardsmen who were instructed not to let the residents leave.³⁹ The local planters feared with good reason that many of the sharecroppers,

33. See JONES, *supra* note 30, at 198–224 (using information from the American Red Cross to discuss the people that were displaced and the efforts the Red Cross undertook in their relief effort).

34. See JONES, *supra* note 30 and accompanying text; see also JOHN M. BARRY, *RIISING TIDE: THE GREAT MISSISSIPPI FLOOD OF 1927 AND HOW IT CHANGED AMERICA 192–97* (1998) (noting how much work was to be done during the floods and that the more difficult labor was given almost exclusively to blacks who were beaten, jailed, or shot if they refused to work).

35. See JONES, *supra* note 5, at 208–210, 214 *citing* JOHN PAYNE, *AMERICAN NATIONAL RED CROSS, THE MISSISSIPPI VALLEY FLOOD DISASTER OF 1927: FINAL REPORT OF THE COLORED ADVISORY COMMISSION 100–05* (1929).

36. See *id.*

37. See *id.*

38. See J. Winston Harrington, *Rush Food and Clothing to Flood Victims*, *CHICAGO DEFENDER*, Apr. 30, 1927, at 1.

39. See JONES, *supra* note 5, at 216.

provided with free transportation by government and Red Cross boats, would decide to leave the area for the industrial North where racial and employment conditions were somewhat better.⁴⁰ Most infamously, local planters in Greeneville, Mississippi, set up a heavily patrolled long-term camp for black residents along the muck of the town's levy.⁴¹ As one report noted, the levy tops were concentration camps of misery and disease, where "[m]ud, rain, cold, hunger, exposure [and] hopelessness led to fatal results."⁴²

Now food rations at the refugee camps throughout the flooded area, according to the Red Cross's own reports, were limited to sparse regimens of salted meat, beans, sugar, salt, potatoes, cornmeal, flour, and rice. They excluded dairy products, fruits, and vegetables entirely. With vegetable gardens flooded and cattle drowned, people had no inexpensive way to supplement this inadequate diet with fruits, vegetables, and dairy products.⁴³ As a result, rates of pellagra, a disease caused by a dietary deficiency of niacin, shot up. U.S. Public Health Service officials, more than a decade earlier, had documented that pellagra, which causes skin rashes, diarrhea, dementia, and death, was endemic among the poor black and white Southerners, with rates higher among African Americans due to their greater rates of poverty.⁴⁴ Now the Red Cross sought the advice of the Public Health Service to try to stem the epidemic of pellagra following the flood.⁴⁵ Nutritional yeast proved helpful but came too late to prevent many cases.⁴⁶

In June, when the flood waters began to subside, many black sharecroppers were rounded up and forced to return to the still-flooded plan-

40. See JONES, *supra* note 5, at 216–217 (citing J. Winston Harrington, *Use Troops In Flood Area to Imprison Farm Hands*, CHICAGO DEFENDER, May 7, 1927, at 1).

41. See JONES, *supra* note 5, at 208.

42. *Id.* at 207 (citing Report to Grand Lodge of Masons, *United Masonic Relief in The Japanese Earthquake of 1923, the Florida Hurricane of 1926, the Mississippi Flood of 1927, the Porto Rico Hurricane of 1928, and the Florida hurricane of 1928*, at 18 (1931)).

43. See *id.* at 209, citing AMERICAN NATIONAL RED CROSS, Army Memos, RG 200 (1927).

44. See Joseph Goldberger, *The Etiology of Pellagra: The Significance of Certain Epidemiological Observations with Respect Thereto*, 29 PUB. HEALTH REP. 26 (Jun. 26, 1914); see also ALAN M. KRAUT, *GOLDBERGER'S WAR: THE LIFE AND WORK OF A PUBLIC HEALTH CRUSADER* 98–99, 119, 188, 216–218 (2003).

45. See JONES, *supra* note 5, at 213.

46. See JONES, *supra* note 5, at 213 (citing C.W. Warburton to James Fieser, group 2, RG 200).

tations where they lived.⁴⁷ Pools of standing water and unscreened cattle exposed them to malaria, another fatal scourge in the South at this time. Now although the Rockefeller Foundation provided matching funds for state and local health departments to increase efforts to fight these diseases following the flood, these efforts were short-lived and ill-supported by Southern state governments, which had little interest in helping the poor black residents whom whites had disenfranchised decades earlier.⁴⁸

But this is not just a story of victimization and neglect. During the flood, the NAACP sent undercover representatives to investigate the reports of racial inequities that were coming out of the flooded area by people who were leaving.⁴⁹ The *Chicago Defender*, which also sent correspondents to the area, kept discrimination against black flood sufferers on its front page. And this chorus of protest led Commerce Secretary Herbert Hoover, who was later known for his ability to keep his head in the sand while we were heading into the Great Depression, to stand up and take notice. Hoover was then serving as head of the President's Special Flood Relief Committee. Hoover organized an official investigation of racial discrimination in the flood [which was] led by a prominent group of African American leaders from Tuskegee Institute and other places.⁵⁰ Now this investigation did not remedy the greatest injustice[s]. [However,] over the long-term, these protests and investigations did pressure the American Red Cross, which was the nation's leading disaster relief organization, to take pains to show that it was trying to treat people of different racial groups fairly. In future disasters, the American Red Cross hired more African American workers in its disaster relief operations, more [African American] nurses, and more [African American] social workers, and at the same time, this effort to fight back empowered black leaders to proactively advocate for greater engagement and increased racial equity in relief following future disasters.⁵¹ So for African Americans, the flood represented both a social disaster that increased their exposure to the neglect and hostility of the Southern plantation whites, and an opportunity to learn how to expose this

47. See JONES, *supra* note 5, at 219 (citing Negro Commission, June 1927 Survey, box 744, group 2, RG 200)

48. *See id.*

49. *See* KENNETH ROBERT JANKEN, WALTER WHITE: MR. NAACP 82 (2006)

50. *See* JONES, *supra* note 5, at chap. 11 (citing THE FINAL REPORT OF THE COLORED ADVISORY COMMISSION APPOINTED TO COOPERATE WITH THE AMERICAN NATIONAL RED CROSS AND THE PRESIDENT'S COMMITTEE ON RELIEF WORK IN THE MISSISSIPPI VALLEY FLOOD DISASTER OF 1927, AMERICAN NATIONAL RED CROSS (1929)).

51. *See id.* at chap. 13–14.

neglect and hostility in order to mitigate the blunt force of future discrimination in disasters.

So what lessons do the 1927 flood, the 1906 earthquake, and the 1926 Miami hurricane hold for us now in 2012? First, and most obviously, they tell us that disasters in the United States, long before Katrina, have been associated with racially disparate patterns of morbidity and mortality. Although causation is sometimes hard to establish when you see them, coming from a public health background and try[ing] to establish causation through statistical studies, a strong association certainly exists, in all of these cases, between racial discrimination and patterns of illness and death. Secondly, disasters throughout American history have exposed underlying racial and socioeconomic health inequities, including those that are caused by poor housing and associated with poor diet. Crowded and unsanitary housing conditions had exposed Chinese San Franciscans to infectious disease long before the 1906 earthquake. Most notably, in 1900, there was a bubonic plague outbreak in [San Francisco], and it hit Chinatown first and hardest.⁵² Similarly, inadequate housing left poor Mississippi Delta residents, most of them African American, more vulnerable to the flood and its health hazards than more affluent whites. But this same inadequate housing—and we are talking about sharecroppers' cabins with no [window or door] screens—had long failed to protect these sharecroppers from sanitary hazards and malaria.⁵³ Dietary deficiencies of poor African Americans and whites in the South were also well known by this time. The Red Cross reproduction of what it called standard plantation rations, together with the enhanced focus on the population [living] in refugee camps following the flood, both underscored the problem and brought it to light. Thirdly, we can learn that disasters and the social disorder that follows them can create a climate where racially-motivated violence can flourish. And this is another place where the law comes in, because following many disasters in U.S. history in the 20th century, the military groups—National Guard or other military groups—were given the authority to shoot-on-sight any looters. And this does not always work out because they use their discretion, and often individuals make mistakes or their own prejudices become acted out.⁵⁴

52. See MARILYN CHASE, *THE BARBARY PLAGUE: THE BLACK DEATH IN VICTORIAN SAN FRANCISCO* 11–13 (2004).

53. See MARGARET HUMPHREYS, *MALARIA: POVERTY, RACE, AND PUBLIC HEALTH IN THE UNITED STATES* 79–80 (2001).

54. See Jones, *supra* note 30, at 179 (citing CONNOLLY, *supra* note 27, at 41–42). See also *\$100,000 for Relief Sent By Red Cross*, N.Y. TIMES, Sept. 28 1926, at 6; *Affidavit Says*

Now this pattern of racially-motivated violence also happened during Katrina where there was a well-documented instance of [a] posse of heavily armed white young men who killed as many as eighteen black men, and the crime went unreported until investigated by journalists years later.⁵⁵ Now in the 1920s disasters discussed here the violence more often took the form of forced labor than murder sprees. But there is little fundamental difference between outright murder and [the] drowning death of men who had the choice of fighting the Mississippi or facing the butt of a sawed-off shotgun.

Lastly these case studies of disasters suggest that neglect, especially neglect in an emergency situation, can more negatively affect the health and mortality of minority and underserved populations than any other form of discriminatory treatment. Failure by governmental and non-governmental actors to provide people with adequate food, shelter, medical attention, safety, and assistance in rebuilding their lives is perhaps the most obvious cause of health disparities in disasters. Sometimes the effect of this neglect may not become apparent until months or years later, as in the case of tuberculosis in San Francisco. But there appears to be a clear relationship between this immediate short-term neglect and long-term health vulnerabilities, [and this] deserves more attention. So in summary, by beginning to look at these historical case studies of disasters and how different populations have been treated in widely divergent contexts, we can help to begin to identify the most enduring sources of disaster-related health disparities, and then we can formulate policy, including formal laws, that seeks to address these issues and bring an end to such inequities.

Defender *Was Right in Miami Case*, CHICAGO DEFENDER, Dec. 4, 1926, at 1; (relating the shootings of unarmed black Miamians following hurricane); FRADKIN, *supra* note 23, at 140–141 (detailing the shooting of alleged looters following San Francisco earthquake); *Negroes Caught Pillaging Shot by Soldiers*, NEW YORK WORLD, Sept. 13, 1900, at 2; *Many Negroes are Arrested*, THE ATLANTA CONSTITUTION, Sept. 13, 1900, at 2 (describing the shooting of alleged “negro” looters following 1900 Galveston, Texas Hurricane)).

55. A.C. Thompson, *Katrina’s Hidden Race War*, THE NATION, January 5, 2009, available at <http://www.thenation.com/article/katrinahidden-race-war> (last visited Feb. 13, 2013) (on file with the WASH. & LEE J. CIVIL RTS. & SOC. JUST.).