

III. Civil Rights

IN HEALTH CARE

SLAVERY AND RECONSTRUCTION

AFTER THE SOUTHERN SLAVES were set free by the Emancipation Proclamation, their health status and health care declined sharply. This paradox becomes easy to understand if we recall that slaves were valuable property because the fruit of all their labor and all of their children were assets of the master. The state of medical knowledge in the antebellum South was of course on a low order. Large plantations commonly employed a White physician and usually had a hospital or infirmary with older slave women as nurses or attendants (Morais 1969, 11–20; D. B. Smith 1999, 11–12), but we should bear in mind that only 2 percent of slaves lived on plantations with 250 or more slaves while the overwhelming majority lived with families holding 15 or fewer slaves (Fogel and Engerman 1974; Fogel 1989, 178–79). The enslaved population increased from close to 700,000, or 25 percent of the nation's total population in 1790, to close to 4 million in 1860. Some 250,000 were brought in illegally after the end of slave importation in 1808, with growth in the slave population thereafter due to natural increase (*New York Public Library* 1999, 32). The average slave woman during the child-bearing years gave birth to slightly more than nine children (Fogel 1989, 14, table 4; among Caucasians, "American marriages yielded, on average, about eight live births . . . and half of these children lived to maturity" [115]). This was roughly twice the number of children born to a slave woman in Trinidad, most likely due to the shorter fertility span and higher death rates of slaves in Trinidad. Generally slaves fared worse on the large sugar plantations in the tropics.

Newborn babies were small in size, most of them probably weighing less than 5.5 pounds, making them vulnerable to early death from diarrhea, dysentery, whooping cough, and a variety of respiratory diseases. Malnutrition probably was a major cause of the low birth weight and con-

tinued in the early years of life, accounting for the fact that death rates for slave children were twice those of White children (Fogel 1989, 143). The excess death rate for children under five accounts almost entirely for the higher mortality rate for slaves as compared to Whites.

That adult slaves in the United States enjoyed relatively good health is indicated by the fact that life expectancy of slaves and Whites was similar after age twenty. Analyses of cotton picking and other fieldwork schedules suggest that pregnant women worked with little letup until the last weeks of their pregnancies, returned to work after a month, and were at full schedules by the fourth month, suggesting that their babies were weaned early (Fogel 1989, 146).

Computations based on 1850 census data indicated that the average death rate due to pregnancy among slave women aged twenty to twenty-nine was just “one per thousand . . . not only low on an absolute scale, it was also lower than the maternal death rate experienced by southern White women.” Fogel and Engerman (1974, 123) go on to note that the infant mortality rate in 1850 was 183 per thousand for slaves, while for Whites nationwide it was 146 per thousand, or 20 percent lower. Most of this difference vanishes when we note that the infant mortality rate for southern Whites in 1850 was 177 per thousand, “virtually the same as the infant death rate of slaves” (124). These figures would suggest that life in the South generally was not as favorable.

The rapid influx of European immigrants into New York, Philadelphia, and Boston in the period 1820–60 greatly exceeded job opportunities available to them, resulting in high rates of crime, homelessness, poor health, and alcoholism. “Life expectancy at birth for persons born in New York and Philadelphia during the 1830s and 1840s averaged just twenty-four years, six years less than that of Southern slaves” (Fogel 2000, 58, 59). Fogel and Engerman (1974, 258–64) maintained that the abolitionists had deliberately exaggerated the brutality of slavery, understandably to rally opposition to the inhumane and degrading nature of the institution. In the process of emphasizing its cruelty, Blacks inadvertently were depicted as a group of totally demoralized and victimized incompetents. Thus the Black slave was seen as inferior for reasons of social oppression, but nonetheless as inferior as though it were genetically induced. It was that distortion of history that constitutes a racist attack on Black people, making it appear that they are beyond hope for betterment. By calling attention to the strength of Black people, even under enslavement, in terms of physical health, labor productivity, and as skilled artisans and managers of plantations, Fogel and Engerman did not intend to glamorize or excuse

the injustice of slavery, but simply to set the facts straight. Even in the strength and stability of their family life, the slaves were more successful than commonly supposed.

W. M. Byrd and L. A. Clayton, in their comprehensive medical history of African Americans, paint a gloomier picture of the health of Blacks in the antebellum South (Byrd and Clayton 2000a). Primarily citing the work of T. L. Savitt, they point out (285) that overall mortality rates for slaves in rural or urban communities were almost one and a half times higher than for Whites (Savitt 1978). Byrd and Clayton showed that slaves were extensively used as research subjects by White southern physicians like J. Marion Sims, often referred to as the father of gynecologic surgery for his discoveries in 1830 to 1850 on the repair of vesicovaginal fistula and his invention of surgical instruments used in obstetrics and gynecology. Similarly, Crawford Long used slaves extensively in his 1842 discovery of ether anesthesia for patients undergoing surgery.

With the end of slavery, White Southerners no longer had a vested interest in the welfare of Blacks. In the immediate postemancipation period, many planters tried to reconstruct their plantation work gangs on the basis of wage payments, but the freedmen rejected these incomes, which would have exceeded “by more than 100 percent” their real earnings as slaves. Once free, slaves rejected forced labor in gangs because of its “nonpecuniary disadvantages” (Fogel and Engerman 1974, 237–38). As a free agricultural worker farming on a sharecrop arrangement, with no protection against exploitation, the freedmen were on a rapid downhill course that brought them back essentially to a condition of hostile reenslavement.

Life expectancy for slaves in the 1880s and 1890s declined by 10 percent compared to the quarter century before the Civil War. Their diet deteriorated; sickness rates by the 1890s generally were 20 percent higher; they were driven out of the skilled crafts that they had previously dominated; and they were barred from membership in labor unions. Only with World War II did this trend reverse itself, and since then decade by decade there has been a reduction in differential life outcomes between Blacks and Whites, which revives a sense of possible improvement (Fogel and Engerman 1974, 261). Fogel and Engerman agree with (1974, 261) Gunnar Myrdal, who, in *The American Dilemma*, observed that the surviving system of color caste in some limited respects was a more precarious economic arrangement than slavery. As David Barton Smith reminds us (1999, 21–24; see also Hoffman 1896), near the end of the nineteenth century a number of commentators claimed that because Blacks had an infe-

rior constitution, which made them vulnerable to diseases like tuberculosis, and were prone to sexual promiscuity (resulting in venereal disease), drug abuse, and alcoholism, they would probably become an extinct race within a few decades. Social Darwinism was becoming widely accepted in that era; survival of the fittest was the way it was and should be. A dramatic worsening of the health status of Blacks was seemingly confirmed by the census in 1870, 1880 and 1890; in 1890 for the first time the Black birthrate was lower than the White (Byrd and Clayton 2000a, 411). A prominent health care statistician, Frederick Hoffman, predicted that the Black race would be extinct by the year 2000, and his work convinced most insurance companies that Blacks were uninsurable.

In the antebellum census of 1850, the life expectancy of slaves was 36 years, 12 percent below the average 40 years for White Americans. In 1890, life expectancy for Whites was 47.6 years, for Blacks 33 years, a 30.7 percent difference—illustrating how much less support the social system was giving to Blacks as free men and women (Fogel and Engerman 1974, 125–26). Fogel (1989, 179) summarizes studies on family stability among slaves and concludes that it was closely related to plantation size. For the 43 percent of all slaves who lived on plantations where there were fifteen or fewer slaves, only one-third of the children were raised in two-parent families; on larger plantations, two-thirds of slave children lived in families headed by both parents. The general family pattern was that the father was head of the house. We should note that in the 1990s two-thirds of Black children were in single-parent homes, as compared to 24 percent in 1960 (Jaynes and Williams 1989; *New York Public Library* 1999), reflecting a relatively recent decline in family structure that has disproportionately affected African Americans.

SEPARATE BUT EQUAL

If Congress had acted favorably on the radical Republican proposal to give each slave family forty acres and a mule as startup capital after the Civil War, debilitating poverty could have been prevented in ensuing generations. The Homestead Act of 1862, passed before the end of slavery in 1865, gave 1.6 million White families up to 162 acres each if they agreed to live on and farm what had been public land. In the same year the Morrill Act established the land-grant colleges, which were almost exclusively for the benefit of Whites. Subsequent amendments provided additional funds in 1890 and again in 1907 (see J. O. Smith 1987, 19–61, who details land giveaways to Caucasians from the colonial period; and Cross 1984, 495–526, esp. 516–17). Smith points to these as examples of economic, educational,

and civil rights for Whites, guaranteed by law and birth, while rights for Blacks depended historically on the kindness and good grace of their adversaries and competitors. In a highly competitive and adversarial society, this is not good. For example, seventeen so-called Black colleges were set up by states; these were required under later revisions of the Morrill Act to provide separate but equal schools for Blacks. As of 1916, not one of them provided college-level courses leading to a bachelor's degree; all were boarding schools teaching elementary and high school subjects (Jones and Weatherby 1978, 102–3).

When the slaves were freed, they were left penniless and homeless, their plight so desperate that in 1865 Congress empowered the president to appoint a commissioner to direct the Freedman's Bureau, to look out for their welfare and education. Blacks had a driving need to own land, and the commissioner had authority to lease unoccupied tracts of land and sell it to ex-slaves after a period of three years. Rents paid by the freedmen, who were not allowed to have more than forty acres each, amounted to \$400,000, an amount that practically paid for the Bureau's operation during the first years. A Freedmen's Saving and Trust Company was established by a group of philanthropic supporters who arranged for it to be chartered by the federal government and for two-thirds of its assets to be in government securities. Headquartered in Washington, D.C., there were twenty-seven branches situated primarily throughout the South. The bank remained strong from 1865 until the early 1870s despite strong opposition from Whites who resented the presence of banks within their states that they could not control. Southern Whites gained control with a bill that Congress approved allowing changes in the Board of Trustees membership, which reduced the proportion of deposits invested in federal government bonds, allowing other notes and real estate mortgages as collateral. As J. O. Smith states, this opened the bank's vault to predators, and within three years the hard-earned savings of many newly freed men were lost (1987, 108–9). While the Freedmen's Bureau controlled 800,000 acres of land in 1865, by 1868 the amount was reduced to fewer than 140,000. The Bureau was phased out in 1872, leaving only the philanthropy of church denominations to aid in setting up Black schools and colleges. The Freedmen's Bureau's medical department had set up more than ninety hospitals and dispensaries in the South but by 1868 closed all except the largest and strongest one, Freedmen's Hospital, on the grounds of Howard University.

Both Howard University Medical School and Meharry Medical College were established under the auspices of the Freedmen's Bureau. Morais

(1969, 39–58) discusses the histories of these two institutions. Howard opened in 1868, with the stated objective of admitting Blacks or Whites, although it was “primarily intended to train colored doctors.” One of their first eight students was White. Of the five initial faculty members, one was a Black physician who had been educated in Canada. At first classes were held only in the late afternoon and evening, not only because students had to hold jobs during the day, but also because the White faculty members were also on the faculty of the medical school at Georgetown University. They encountered great pressure to resign from their association with Howard at the risk of losing or being demoted from their Georgetown appointments. They persevered, and Howard gained a good reputation and membership in the Association of American Medical Colleges.

Unlike Howard, Meharry was established in 1875 solely for the education of Negro doctors, first as a part of Central Tennessee College supported by the Freedmen’s Aid Society. It became a freestanding school in 1915. Unlike Howard, which was funded by the federal government, Meharry was financed privately. Its first building, to accommodate the first dozen students, was built with funds from the five Meharry brothers, White businessmen who were showing their gratitude to Blacks who had helped them in their early careers.

Between 1869 and 1900 ten Black medical schools were established (Watson 1999, 23–43). Flexner’s 1910 report on the nation’s medical schools concluded that, of the seven Black schools then in existence, only Howard and Meharry were strong enough to warrant continued support. Flexner’s endorsement made a medical school eligible for a portion of the \$100,000,000 made available by the Rockefeller General Education Fund to establish a stronger scientific base for medical education. Only rarely did a medical school in the East, such as Harvard, Yale, or Penn accept a Black student. Midwestern schools, like Michigan, Indiana, and Northwestern accepted Blacks only a bit more frequently. Thus, as of 1895, there were 365 Negro physicians, only 27 (7 percent) of whom had graduated from White schools. In 1905, of the 1,465 Black doctors, 213 (14.5 percent) were graduates of White institutions. From 1905 essentially until the affirmative action programs began in 1970, the unofficial quota of Black graduates from predominantly White medical schools remained the same (Morais 1969, 60).

It is important to note that Flexner had a limited view of the role of Blacks as physicians, believing they could do more good as public health sanitarians in rural communities than practicing as surgeons in the cities. He further believed that Black physicians would only treat Black patients,

who would be better off with well-educated Black physicians than poorly educated White ones (Morais 1969, 230).

AN EQUAL RIGHT TO HOSPITAL CARE:
THE TUSKEGEE VETERAN'S
ADMINISTRATION HOSPITAL

Blacks were largely excluded from the American hospital system until the legal end to most racial barriers in the 1960s, as is illustrated by the events surrounding the opening of the Tuskegee Veteran's Administration Hospital, established in Alabama in 1923 specifically to care for Black veterans. Black people have had a long struggle to gain equal access to hospitals, either as patients who need care or life-saving treatment, or as attending physicians with privileges to admit and care for their sick patients, or professional nurses. Like many important and shameful racial stories, this one has seldom been exposed to public review (Morais 1969, 112–16).

After fighting to make the world safe for democracy, many soldiers who returned from World War I required hospital care for mental and physical disabilities they sustained during military service. The Veterans' Bureau, finding hospital facilities around the nation inadequate to meet the needs of veterans, built hospitals to provide suitable care. Black veterans were excluded outright from these hospitals or forced to accept beds only on segregated wards. The problem was particularly acute in the southern states, where three-fourths of the four hundred thousand Black veterans lived at that time.

Around this same time Booker T. Washington in effect advised Blacks not to agitate or struggle for their political and civil rights, but rather to remain in the South and make an accommodation to the separate and second-class status imposed upon them. He believed that by quietly promoting their vocational and economic development, they would eventually become accepted as equal Americans. Washington's philosophy was anathema to W. E. B. DuBois and his more militant Black colleagues and White collaborators. DuBois and others founded the National Association for the Advancement of Colored People in 1910. Their goal was to free Blacks from the restrictions of color caste and to gain for them every single privilege of first-class citizenship. Even Robert Moton, president of the Tuskegee Institute—founded by Booker T. Washington, who died in 1915—was sympathetic to this newer and more self-respecting point of view.

Pressure from Blacks for more decent and equal care continued until the Harding administration sought Moton's advice and assistance. In response to Harding's request for help, Tuskegee gave the United States gov-

ernment five hundred acres of land, a mile from their campus, as a site for the construction of a veterans' hospital to be used for Blacks from any part of the nation. It is difficult to imagine that the president of the United States would have to accept the advice of and then a gift from the president of a Black college in the South before decent hospital care was grudgingly extended to Black war veterans.

With the gift came the stipulation that the hospital would be staffed by Black physicians and nurses. Built at a cost of \$2.5 million, the six-hundred-bed hospital was completed in 1923. To the surprise of Moton and other Blacks, the Veterans' Bureau appointed not only a White physician as head of the hospital, but also a full staff of White physicians and White nurses. Black nurses' aides were appointed in order to limit the direct contact between the White nurses and the Black male patients. When Blacks insisted that Black professionals replace the Whites, the Ku Klux Klan marched, held nighttime demonstrations, and made death threats. But Blacks persisted, and in July 1924 a Black physician was made director. By the end of the 1920s, Black physicians, including those with specialist training, ran the entire hospital. In the 1930s no other Black hospital in the country, including those associated with Howard and Meharry, could equal the facilities, staff, budget, or residency training programs of the veterans' hospital at Tuskegee. (A detailed history of the political struggle to gain Black control of this hospital, and of the decision to locate it at Tuskegee, has been provided in exemplary scholarship by Vanessa N. Gamble [1995; see esp. 70–104]).

By the end of the 1930s Tuskegee's hospital had grown to fifteen hundred beds, about half dedicated to psychiatric patients, while the rest were for general medical and surgical cases. By that time some of the northern states had begun to admit as patients their Black veterans who required hospitalization and to treat them more equally.

Given the presence of highly trained Black specialists in medical and surgical fields, it remains a source of amazement that the Tuskegee syphilis experimental study was conducted there, in Macon County, Alabama. Begun in 1932 and lasting until 1972, it was perhaps the longest experiment in withholding treatment from human subjects in medical history. The study, conducted by the United States Public Health Service, with the full collaboration of Tuskegee Institute, involved following the untreated course of syphilis in 399 Black men from that rural area who had the disease and who were given no treatment even after the 1940s when it was known that penicillin was an effective cure. Researchers compared their clinical course with another 201 Black men who did not have the disease.

As David Barton Smith (1999, 25–28) points out, this reflects badly on the sense of medical ethics and fairness on the part of Black and White professionals. “It was not a secret experiment conducted by rogue researchers. Outside professionals regularly reviewed the project’s protocols. More than a dozen publications were generated and were widely read . . . even after the county medical society had become a predominantly black body in the late 1960s the project continued to receive full support including the referral of patients to the project’s control group” (26). Tuskegee Institute’s administration and its private hospital located on campus (John A. Andrew Hospital) cooperated fully with this research, allowing its facilities to be used in medical evaluations of these men. The Veterans’ Administration hospital did not cooperate as fully, although their staff pathologist performed autopsies on the more than one hundred men who died in the course of the research, and sent organ specimens to the National Institute of Health for definitive study (Jones 1981, 122–50).

My speculation is that neither Black nor White middle-class and educated physicians could put themselves in the place of those uneducated Black farmhands who had syphilis. The public learned of the project in 1972, and it was halted quickly; but despite the fact that the federal government has paid more than 10 million dollars in an out-of-court settlement to surviving participants and their families and heirs, it has left a lasting monument to the power of indifference to the mistreatment of uninformed and vulnerable Black men.

AN EQUAL RIGHT TO HOSPITAL CARE:

LOUIS T. WRIGHT AND

HARLEM HOSPITAL, 1919–52

John Knowles (1973) made the point that the hospital system is a barometer of our social values and belief systems at any given time. Much of our voluntary hospital system was developed by religious denominations, with hospitals specifically labeled as Protestant, Catholic, or Jewish and with special service missions for their own groups. At first these hospitals were built and financed by wealthy contributors from their religious constituencies. The public charity hospital system had the residual responsibility of caring for the sick poor who were otherwise left out of the voluntary-sectarian hospital system. However, these hospitals were generally closed to Blacks by law in the South, and by custom and practice elsewhere. Meanwhile, modern urbanization of the American population was simulating the development of large city hospitals. The medical profession’s need for teaching and research facilities strengthened the growth

both of the large voluntary-sectarian hospitals and of large public charity hospitals.

One of these large public charity hospitals was Harlem Hospital in New York City; and the story of the battle to open it up for Black staff is most revealing (Corwin and Sturges 1936; Morais 1969, 117–28; Reynolds 2000). Following World War I, the Black migration to New York City had surrounded Harlem. By the 1920s, many newspaper stories began to recount the inadequate, incompetent and unfair treatment accorded to the large number of Black patients crowding into Harlem Hospital.

Dr. Louis T. Wright was the first Black physician appointed to the medical staff of Harlem Hospital, and he is the leading figure in this powerful story. Both his father, who died young, and his stepfather were Black physicians and prominent leaders in the Atlanta community. In 1897, his stepfather, William Fletcher Penn, was the first Black to graduate from Yale University Medical School. Although he was first in his class, Penn was unable to find postgraduate training in the East, so he completed an internship at Freedmen's Hospital in Washington, D.C. He then founded a Black hospital in Atlanta and established an interracial practice. In 1925 Penn accepted the position of chief of surgery at the Veterans Administration Hospital at Tuskegee, where he remained until his death in 1934.

Louis T. Wright graduated fourth in his class from Harvard Medical School in 1916, but also could not find training at a teaching hospital and had to go to Freedmen's Hospital, where he performed brilliantly. He volunteered for military service and, while serving in France, worked side by side with White physicians and nurses on surgical wards, where he soon was put in charge.

In 1919, Dr. Wright was the first Black physician appointed to the medical staff of Harlem Hospital, though at the lowest possible rank. The White hospital director of Harlem Hospital was immediately denounced for making the appointment and forced to transfer to another city hospital. Four White physicians resigned from the Harlem Hospital Center's staff rather than work with a Black physician. Another prominent White surgeon resigned from the staff after a nursing school to train Black nurses was established in 1923. He refused to have a Black nurse assist him in the operating room. By 1929, of sixty-four physicians and surgeons on the staff of the hospital, only seven were Black. Not until the following year was the staff reorganized, and in 1930 the salaried staff to care for inpatients included nine Black physicians. In that same year another seven Black physicians were in the outpatient department, and nine Blacks were appointed as interns. Nineteen dentists were added in 1931.

A study prompted by the National Association for the Advancement of Colored People concluded in 1935 that Harlem Hospital was important because it was the only hospital in the country where Black physicians were on the same footing as the White members of the staff and enjoyed exactly the same privileges. Moreover, it was one of the very few hospitals, outside of the so-called Black hospitals, that admitted Blacks as interns. That is why all that pertained to Harlem Hospital assumed a national importance.

Nevertheless, only four Blacks applied for internship in 1933, and many Black physicians in the Harlem community expressed heated criticism of Dr. Wright, claiming that he favored the Black graduates of predominantly White medical schools over the graduates of Howard or Meharry. Indeed, for at least another decade, a lively controversy existed within the Black medical community in Harlem concerning the wisdom of establishing an all-Black hospital, completely controlled and staffed by Blacks for Blacks, a movement that Dr. Wright vigorously opposed and that never gained wide support. Into the 1930s and 1940s Harlem Hospital continued to provide internship training for many able Black physicians graduating from all the nation's medical schools. Its racially integrated professional staff achieved a level of excellence—especially in its surgical training program, led by Dr. Wright—that brought it recognition throughout the national medical community (see Maynard 1978, for an excellent account by the surgeon who succeeded Dr. Wright as head of the Harlem Hospital Center Department of Surgery).

In 1931, data from the American Medical Association, and from a special study by the Jules Rosenwald Fund, showed that 122 hospitals, distributed throughout twenty-eight states and the District of Columbia, would accept Black patients. Of these, the only hospitals with a two-hundred-bed or larger capacity were tax supported: two of these were federal and two were city hospitals. Another two state hospitals, a county and a city hospital, had bed capacities between one hundred and two hundred. Seventy percent of the hospitals for Blacks only were of less than five-hundred-bed capacity, and half of them had fewer than twenty-five beds each. Of all these Black hospitals, the AMA had approved internship training programs in fourteen, although many were pitifully weak. Two of the strong and well-established hospitals with all-Black patients accepted only White men as interns: Grady Hospital in Atlanta, associated with Emory University School of Medicine, and St. Phillips Hospital in Richmond, associated with the Medical College of Virginia (Corwin and Sturges 1936).

Against that historical background we can see that many gains had been made by 1956, when Reitzes (1958, 329–48) studied the racial pattern

of medical care in fourteen major urban centers of the United States and found that the presence of a Black hospital in a given city influenced, usually negatively, the degree to which a racially integrated pattern of hospital care was being achieved (333). Such a hospital encouraged self-segregation. On the other hand, it could be argued that the presence of Black hospitals merely reflected the extent to which entrenched racial segregation in that city had forced the development of a separate hospital system, in lieu of none at all. Predominantly Black hospitals were absent in the six cities that had the highest degree of integration as measured by an index of the percentage of Black physicians having appointments at predominantly White hospitals. These cities were New York, Philadelphia, Los Angeles, Indianapolis, Boston, and Gary, Indiana. Detroit, where Black hospitals were relatively unimportant, was the seventh most integrated, followed by cities with important Black hospitals: St. Louis, Chicago, Kansas City, Washington, D.C., Atlanta, Nashville, and New Orleans (Reitzes 1958).

An exception to the self-segregationist trend was Washington, D.C., where two very strong Black institutions, the Howard University College of Medicine and its affiliated teaching hospital, Freedmen's, nevertheless produced Black leaders who pressed for racial integration of the hospital system in our nation's capital (Reitzes 1958, 338). In 1956 Washington ranked third among cities in number of Black physicians, with 224; New York was first and Chicago was second. But regarding the number of board-certified specialists, Washington was first, with fifty-eight; Chicago with forty-two was second; New York with forty was third. Medical integration, however, had begun seriously in Washington only in 1948. That was the first year that Black physicians were accepted as members of the attending and resident staffs of the Gallinger Municipal Hospital (now the District of Columbia General Hospital); Children's Hospital opened up its training program in 1955. Black physicians were not accepted as members of the Medical Society of the District of Columbia until 1952, the same year that Hadley Memorial Hospital first opened its doors to Black patients and staff. The Health Department desegregated its programs in 1953. In 1954, for the first time, a Black physician was appointed to the staff of the teaching hospital of George Washington University. In 1955, George Washington University Medical School admitted its first Black student; by that year Georgetown had accepted several, but none had enrolled. Most of these gains came as the result of steady integrationist pressure from the Black faculty members and alumni of Howard University (Reitzes 1958).

THE END OF RACIALLY SEPARATE HOSPITALS

The United States Supreme Court did not outlaw racially segregated hospitals until 1964, ten years after the legalized end of public school segregation. Following World War II, the Hill-Burton Hospital Construction Act of 1946 provided the means by which \$2 billion in federal funds were spent building an improved hospital system for the nation. Out of deference to southern custom, and specifically to obtain the strong support of Senator Lister Hill of Alabama, localities were allowed to build “separate but equal” hospitals, or wings of hospitals, for Blacks and Whites, as long as the state plan nominally provided for equal hospital care for both races. This was modeled on “separate but equal” language in the Morrill Land Grant College Act, which financed inferior educational institutions for Blacks. Not surprisingly, these federal funds had the effect of escalating the building of new edifices for racial separatism. By 1949, as many as 214 hospitals built with Hill-Burton funds were racially separate in whole or part, and 4 had been built exclusively for Blacks. In 1962 and 1963, civil rights proponents in the Congress, led by Representative John Dingell from Michigan and Senator Jacob Javits from New York, introduced bills to require hospitals that received Hill-Burton funds to admit Black patients and to give staff privileges to Black physicians. These legislative efforts failed. It was, moreover, the opinion of chief legal counsel for DHEW that, while patients could not be denied admission to those portions of so-called nondiscriminatory facilities built with Hill-Burton funds, such facilities were not required to grant staff privileges to Black physicians, nor was it required that Blacks be accepted into their postgraduate or other training programs (Morais 1969, 180–82).

In 1963 a group of Black physicians, dentists, and patients sued two hospitals in Greensboro, North Carolina, for refusing to accept Blacks as patients or professionals. This dramatic story is covered in wonderful detail by David Barton Smith (1999, 91–114; see also Morais 1969, 180–98). These litigants argued that the “separate but equal” provision of the Hill-Burton act be declared an unconstitutional denial of their Fourteenth Amendment equal protection rights. In that same year, in the case of *Simpkins v. Cone Memorial Hospital*, the federal district court in North Carolina decided against the plaintiffs, but on appeal the Fourth Circuit Court reversed this decision and granted the relief sought by the Black plaintiffs. Throughout the land, Blacks were jubilant about this victory.

Interestingly, the *Journal of the American Medical Association* gave the case scant acknowledgment, mentioning it in a column on Washington

news ("Miscellany—Segregation" 1963). The defendant hospitals immediately appealed the case to the Supreme Court, which refused in 1964 to hear the appeal, thereby letting stand the decision of the Fourth Circuit Court of Appeals. Again the matter was treated lightly by *JAMA* ("Washington News" 1964). *JAMA* explained that, while the equal protection clause only protects persons from unequal government actions, the voluntary hospital had received Hill-Burton funds in an amount judged by the court to be sufficient to bring them under this constitutional requirement. Cone Memorial had received \$1.2 million in federal funds but had refused to give Black doctors and dentists staff privileges, although they had admitted a few Black patients. Long Hospital, another party to the legal action, had received \$2.9 million and was closed to Blacks either as patients or as professional staff. The reader was left to ponder whether it was a correct interpretation that those voluntary hospitals were considered to be acting as government agencies. There was no reference to any medical or moral issue. This was not the end of AMA activity, however. It became known, and was reported by Montague Cobb in the *Journal of the National Medical Association*, the Black medical journal, that an AMA representative appeared before a congressional committee requesting legislation to exempt private or voluntary nonprofit hospitals that received federal funds from being considered as public or governmental agencies (Cobb 1964). No such legislation was ever introduced. In fact, later in 1964, after a ten-year court contest, Black physicians won a still more decisive case, bringing about substantially more equal hospital rights. In the case of *Eaton v. Walker Memorial Hospital*, a hospital in Wilmington, North Carolina, was required to cease all racial exclusionary practices even though it was not a recipient of Hill-Burton funds as such; other funds from the city and state government had gone to that hospital, entitling Blacks to equal hospital treatment.

Title VI of the Civil Rights Act of 1964 mandated nondiscrimination in federally assisted programs on pain of losing their funds, requiring federal agencies to promulgate regulations translating those requirements into action. The regulations of DHEW that implemented that act explicitly prohibited racial discrimination in patient admissions, as well as any separate or different treatment on account of race, nor could there be racial discrimination in the selection of interns, residents, nurses, student nurses, and other trainees, or in granting professional staff privileges or appointments.

The 1965 Medicare and Medicaid amendments to the Social Security Act brought a still greater amount of federal funds into the financing of

hospital care. We should note that while the American Public Health Association and the American Nursing Association supported passage of Medicare and Medicaid, the American Medical Association not only vigorously opposed these laws financing medical care for the elderly and the poor but tried unsuccessfully to have the Black National Medical Society fight it (D. B. Smith 1999, 115–28). Civil rights compliance was energetically pursued by DHEW in those early years, with five hundred staff members assigned to review the policies and practices of eight thousand hospitals, many of them being credited with changing their racial behavior. Unfortunately, by the mid-1970s the federal political climate and administration had changed, and on-site inspections or the actual use of a fund cutoff was widely viewed as an empty threat. In fact the rules had been rendered more obscure and vague, and both staff and budget to enforce civil rights compliance had been reduced to symbolic proportions.

As David Barton Smith explains, the Office of Civil Rights within the then Department of Health, Education, and Welfare (DHEW) was in 1977 given responsibility for enforcing Title VII prohibitions against denial of equal rights to Blacks, but actually much more compliance staff time and thought were devoted to school desegregation than to health services. When DHEW was reorganized under the Carter administration, the Health Care Financing Administration (HCFA) gained authority over Medicare and Medicaid programs, which should have provided more leverage over health care providers. Providers, however, effectively nullified this authority. As one staff member said, “HCFA was a captive of the industry in the late 1970s. . . . We tried for years to get HCFA to include race data. . . . The department never took it on and we never got anywhere” (D. B. Smith 1999, 183–85). When DHEW was transformed in 1980 to become the Department of Health and Human Services, a separate Office of Civil Rights was created, but with the election of Ronald Reagan in November 1980, civil rights enforcement was a dead issue. Even during the Clinton years, the Office of Civil Rights had only one-third as many staff members as in 1979 and had been transformed “from a central driving force into an increasingly isolated, decaying part of the federal bureaucracy” (D. B. Smith 1999, 187).

HEALTH CARE ORGANIZATION RESPONSE TO THE DESEGREGATION MANDATE

David Barton Smith (1999, 317–19) has presented the most telling analysis of the ways in which the health care delivery system responded to this newly mandated desegregation environment. Fundamental changes were

to be expected: There has been a shift away from federally monitored acute hospital care to more state monitored long-term nursing home care, and a great increase in the number of diagnostic and treatment interventions performed on an ambulatory basis as well as increased home-based care. Smith maintains that many of these changes had the intent of minimizing Black and White patients having to share rooms or to sit together, and to increase the likelihood that they would be standing up together while they were receiving care. Black patients are at a disadvantage because of the dearth of privately sponsored ambulatory services and long-term care facilities in their neighborhoods, all of which have forced their greater reliance on teaching hospitals and clinics. All things considered, however, much less rancor and hostility have been associated with hospital desegregation than with school desegregation.

Young physicians still learn to practice on poor and ethnic minority patients, and when they finish their training, they set up practice in suburban areas. Even if they remain in the city, they accept few poor patients because of Medicaid's low reimbursement rates and burdensome paperwork. The chance that a Black patient's cholecystectomy would be performed by a surgery resident in 1962 was 2.5 times higher than a White patient's; in 1972, this likelihood for Black patients had increased to 4.3 times (D. B. Smith 1999, 234). In medical schools that have affiliations with both public general hospitals and private hospitals, the schedules usually are arranged to ensure that the public hospitals are heavily staffed by residents.

Without doubt, however, profound changes for the better occurred following strict Title VI antidiscrimination enforcement in the Medicare program. Health care utilization by Blacks improved dramatically, although disparities still exist. Mortality rates continue to favor Whites by a wide margin in almost all outcome measures, and Blacks receive fewer of the more expensive and technologically complicated procedures.

Another marked difference is that Black-owned and Black-operated hospitals have disappeared. Between 1961 and 1988, seventy Black hospitals closed or merged with historically White facilities either because of financial pressure or a need to meet high standards to continue to attract Black patients (D. B. Smith 1999, 195). Regional Health Systems Planning activity in the mid-1970s, and passage of the Medicare Prospective Payment System in 1983, forced these health care system changes, which would appear to benefit Black patients.

Organizations respond to policy changes. Medicare equal opportunity requirements may have reduced within-hospital segregation—but they may also have stimulated the creation of new proprietary hospital chains,

the relocation of hospitals from the inner city to the suburbs, and a change in the mix of acute and chronic patients receiving care within the same hospitals. An index of segregation represents the proportion of Blacks and Whites who would have to move to create an equal distribution of the two groups, with 1 meaning that 100 percent would have to move. In fiscal year 1993, there were a total of 11 million Medicare acute care hospital discharges, 84 percent White, 10 percent Black, 3 percent other, and 3 percent unknown; the index of segregation was roughly .53 for the nation as a whole (D. B. Smith 1999, 219). Significantly, the segregation indices for states in the Midwest and Northeast were much higher than for states in the Deep South, where hospitals had desegregated more than other regions. Many southern states' hospitals have indices of .20 to .30, while the Northeast and Midwest range from .40 to .70. Just as public schools in the South currently are less racially segregated than in the North, East, or Midwest, the same holds true for hospitals. De facto segregation now carries more force than de jure segregation.

Hospital practice has changed nationally in ways largely influenced by legal requirements for desegregation. Length of stay has been shortened to the point where ours are the shortest among all developed nations in Western Europe and in Japan, despite the fact that our per capita hospital costs are the highest in the world. Further, over the past thirty years many diagnostic and treatment services have been shifted from inpatient to ambulatory clinics, and many more hospital rooms are now private or for two patients only, another expensive practice not seen to such an extent anywhere else in the world. Smith believes this is often done in part to keep Black and White patients separated.

Even more basic changes are at least in large part racially driven (D. B. Smith 1999, 318). Nursing homes were not held to strict Title VI antidiscrimination standards. Coincidentally, between 1963 and 1973, the number of nursing home beds doubled. A 1981 Institute of Medicine study concluded that Blacks are discriminated against in nursing home admissions, in part because of reimbursement arrangements: nursing home administrations prefer patients whose families can pay the out-of-pocket higher rates; they will keep their certified bed capacities low to avoid increasing state Medicaid budgets, which actually pay for the majority of patients. High and frequently arbitrary selection decisions will therefore tend to diminish chances for a Black to be admitted, and nursing home administrators completely control admission decisions. In years past, many chronically ill Black patients stayed longer in acute hospitals, but the demands for short stay have begun to curtail this practice.

Private physician practice patterns also escaped Title VI antidiscrimination monitoring because physician groups opposed such close scrutiny of office private practice and the increased paperwork it would require. Further, the cost of reviewing physician practice medical records would have been insupportable as well as nonproductive. Indeed, only a small fraction of physicians participate because of the lower rates of reimbursement by Medicaid and Medicare compared to private insurance. With the advent of the managed care medical market, Medicaid, Medicare, and private employer health plans will increasingly force all physicians to begin to enroll all patients who have any third-party coverage. The intimate character of the relationship between the physician and patient is being radically redefined because of restrictions of freedom of choice imposed by managed care.

Residential racial segregation continues to be a fact in most metropolitan areas of the United States. David Barton Smith (1999, 287) reminds us that White Medicaid recipients are geographically diffused throughout residential areas and therefore are more easily absorbed in private practice physicians' caseloads. Black Medicaid patients, recognizing that they are forced to rely more on teaching hospitals and clinics, bring a greater legacy of distrust and fear that they will be receiving inferior and less personalized care. Patient privacy seems to be less assured, with the expected but unfortunate result that sensitive problems such as alcoholism or substance abuse are less likely to be discussed, diagnosed, or treated with professional compassion and are less likely to result in referral for expert and peer group management. These are among the serious ongoing problems that will continue to be a hurdle in our national effort to reduce health care disparities between Black and White Americans. Black physicians still find that about 87 percent of their patients are Black, while only 7.4 percent of White physicians' patients are Black (Health of the Disadvantaged 1977). Improving the health outcomes for Black patients will, of course, depend on improving their access to high-quality, professional, personalized medical care from Black and White physicians, all of whom should be trained to be proud of fulfilling their professional calling to serve all who are in need.

SUMMARY

During slavery the health care and health status gap between Whites and Blacks was less than at any time since Blacks became free. Also during slavery Blacks were more fully employed than at any time since. Beginning with Reconstruction, the health status of Blacks declined; it has only begun to improve with gradual advancement in our national economy and

with Civil Rights activities that followed World Wars I and II, culminating in the civil rights legislation of the 1960s after Martin Luther King's assassination.

De jure hospital segregation ended in the 1960s and 1970s, creating greater but still unequal access to hospitals for Blacks as patients, staff physicians, resident trainees, and nurses. All-Black hospitals have practically ceased to exist, and we should apply sustained pressure to desegregate the hospital system nationwide.

Managed care will present serious challenges to equal treatment of Blacks.