The Politics of Racial Disparities: Desegregating the Hospitals in Jackson, Mississippi

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As health care policymakers and providers focus on eliminating the persistent racial disparities in treatment, it is useful to explore how resistance to hospital desegregation was overcome. Jackson, Mississippi, provides an instructive case study of how largely concealed deliberations achieved the necessary concessions in a still rigidly segregated community. The Veterans Administration hospital, the medical school hospital, and the private nonprofit facilities were successively desegregated, owing mainly to the threatened loss of federal dollars. Many of the changes, however, were cosmetic. In contrast to the powerful financial incentives offered to hospitals to desegregate and ensure equal access in the early years of the Medicare program, current trends in federal reimbursement encourage segregation and disparities in treatment.

Key Words: Race, segregation, disparity, health care.

As health care policymakers and providers focus on eliminating persistent racial disparities in treatment, it is useful to explore how resistance to hospital desegregation was overcome and how the limitations of those accomplishments may be contributing to the persistence of disparities (Agency for Health Policy Research and Quality 2003; Smedley, Stith, and Nelson 2002).

Until the 1960s, as with other aspects of American life, hospital care was rigidly segregated by race in large areas of the United States. In

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much of the South, a separate system of hospitals existed to serve black communities and as a place where black physicians could be trained and practice (Gamble 1995). Even in those northern cities with a sizable black population and where Jim Crow laws did not officially enforce such separation, training opportunities and staff privileges at historically white institutions were offered only to whites, helping ensure an almost equivalent degree of separate and unequal care (McBride 1989). In the South, where economic conditions were worse and access to hospital care was either nonexistent or substandard, the health conditions of blacks at the start of the Great Depression had changed little from the slavery era (Beardsley 1987, 11–71). During the Depression, conditions in the Mississippi Delta impelled Alpha Kappa Alpha, a national black sorority, to establish clinics and forced the state to improve the practices of black lay midwives, who delivered more than 80 percent of the black babies in Mississippi well into the 1940s (S. Smith 1995, 118–67).

At the first conference held by advocates of hospital integration in Washington, D.C., in 1957, Mississippi NAACP representative C.A. Darden noted that little had changed since the 1930s:

> As you know, we are subjected to economic reprisal if we dare stand up for what we believe in. . . . Only one black physician in the state had been admitted to its medical society. Black patients admitted to hospitals are housed in basements or crowded into the halls. Everything in these hospitals is separate, except the sewage, they allow that to flow together. (Darden 1957, 353–4)

It is thus surprising that, with the exception of the military services, hospitals are now probably the most racially integrated social institutions in the United States (D.B. Smith 1999).

What remains unclear is exactly how and why resistance to desegregation was overcome. In contrast to the civil rights struggle in the 1950s and 1960s to integrate schools and public accommodations and to ensure voting rights, hospital desegregation received little public attention. Most of the changes took place quietly behind the scenes and, during this period, involved only a handful of lawsuits, several brief public local demonstrations, and a couple of headlines. Only a few books and journal articles have since been published describing the more public aspects of this struggle (Beardsley 1986; Byrd and Clayton 2001; Quadagno 2000; Reynolds 2004; D.B. Smith 1999).

These accounts trace the efforts of advocates of hospital integration associated with the National Association for the Advancement of Colored People (NAACP), the NAACP Legal Defense Fund, and the National Medical Association, as well as the resulting court cases, federal policy debate, and efforts to use a certification of compliance with Title VI of the Civil Rights Act of 1964 as a condition for receiving funds from Medicare, which was implemented in July 1966. Except for a few anecdotes gleaned from oral histories, it is largely a one-sided story that offers little detail about the nature of the opposition and the enemies encountered in this struggle. As a result, many questions have only unsatisfactory answers. For example, given the obstinacy of opposition to integration in other areas, why were federal officials seemingly willing to risk disaster by forcing the issue with the newly established, complex, and politically fragile Medicare program? Why did the success of this effort catch even its strongest advocates by surprise? Indeed, as one black physician observed after the almost instantaneous collapse of the whole segregationist edifice in his hospital, everyone "acted like it was never any different, like segregation had never existed" (Beardsley 1987, 272).

Fleshing out why and how this resistance disappeared is difficult. Most of the efforts to preserve Jim Crow practices in hospitals were never documented, and most of the few documents that ever existed have long since disappeared. There is no federal paper trail. According to a response to my request under the Freedom of Information Act, records of federal efforts by the Office for Civil Rights and its predecessor, the Office of Equal Health Opportunity, related to Title VI compliance investigations of hospitals during the 1960s were purged years ago in compliance with the federal records retention schedule (Cirrincione 1999). Mainly what is left is oral histories, which supply selective and often overly generous memories of the behaviors of providers and health institutions during the civil rights era (e.g., see Pohl 2000). As with other aspects of this nation's painful and embarrassing record of segregation, many would prefer to leave this side of the story untold.

Jackson, Mississippi: Stronghold of Resistance

This article reviews the efforts to preserve segregation in the hospitals in Jackson, Mississippi. Jackson has two advantages as an example of the often subtle and largely concealed effort to preserve segregation.

First, the defense of segregation in Jackson and of all aspects of social life in Mississippi was more extreme than anywhere else in the nation. Almost half the names listed on a memorial in Montgomery, Alabama, to those slain in the civil rights struggle died in Mississippi. While the Medicare Title VI certification effort at the time the Medicare program was implemented in July 1966 achieved more than 95 percent compliance nationwide, only 34 percent of the hospital beds in Mississippi were in compliance (Berkowitz 2003, 147). In the neighboring states—Georgia, Alabama, and Louisiana—that had also resisted federal pressures, between 80 and 90 percent of the hospitals were in compliance (Pohl 2000, 114). Not surprisingly, Mississippi also had the greatest racial disparities in access to hospital care. In 1946, the ratio of hospital beds to population for Mississippi's blacks was only 43 percent of that of Mississippi's whites, a greater disparity than that of any other state providing strictly segregated accommodations (Dent 1949, 327). In 1946, whereas 87 percent of white babies and 45 percent of black babies in the United States were born in a hospital, the disparity was greatest in Mississippi, where 69 percent of white babies and only 10 percent of black babies were born in such settings (Dent 1949, 326–7). Just as the black community adapted to exclusion from white hospitals by creating black ones, blacks in Mississippi adapted by relying on lay midwives and home births (S. Smith 1995, 118–48). Similarly, whereas in the United States as a whole in 1946, 37 percent of white deaths and 31 percent of black deaths took place in a general hospital, in Mississippi 31 percent of white deaths and only 15 percent of black deaths took place there (Dent 1949, 327).

Jackson is the capital of Mississippi and was at the core of the South's resistance to desegregation (Silver 1964; Vollers 1995). Unlike many areas in the South, where local newspapers provided a moderating influence, the local papers in Jackson served as ardent defenders of segregation during this turbulent period (Davies 2001; Weil 2002). The *Brown v. Board of Education* decision produced massive resistance in Jackson. The Freedom Rides in 1961, the Woolworth sit-in in 1963, and the voter registration drive in the summer of 1964 all sparked violence and national headlines.

The murders in 1964 of the civil rights workers James Chaney, Andrew Goodman, and Michael Schwerner are emblematic of the opposition to integration in the brutal, bitterly divided environment in which Jackson's hospitals and other organizations operated during this period.

Even today, many people in Mississippi believe that the outcome of those murders still stigmatizes their state. Although seven people were convicted of federal civil rights violations surrounding the murders, until this year no one was indicted for murder by the state. Nonetheless, even though Paul Johnson, the governor at that time, was perceived as a moderate on race issues and never was even indirectly implicated, he seems to have had an eerie familiarity with the details. In a 1970 interview, Governor Johnson noted:

> Actually, one thing that is not known to people anywhere in this country is that these Klansmen—of course I knew them very well; most of them had supported me when I ran for governor—did not intend to kill these people. What happened was that they had been taken from jail and brought to this particular spot. There were a good many people in the group besides the sheriff and the deputy sheriff and his group. What they were going to do, they were going to hang these three persons up in a big cotton sack and leave them hanging in the tree for about a day or a day and a half, then come out there at night and turn them loose. They thought that they'd more or less scare them off. While they were talking this Negro boy from over at Meridian [James Chaney], he seemed to be the ringleader of the three—He was acting kind of smart aleck and talking pretty big, and one of the Klansmen walked up behind him and hit him over the head with a trace chain you use, as you know, [for] plowing and that sort of thing. And the end of the trace chain, as you know, is about that large [two or three inches]. . . . The chain came across his head and hit him just above the bridge of the nose and killed him as dead as a nit. After this boy had been killed, then is when they determined, "Well, we've got to dispose of the other two." (Johnson 1970, 32–33)

In addition, not only was Jackson a stronghold of resistance, but the efforts to maintain segregation in Jackson were carefully documented and preserved. No other similar resources as easily accessible appear to exist in any other community. In reaction to the *Brown v. Board of Education* decision, the state legislature passed a bill in 1956 creating the Mississippi State Sovereignty Commission, a permanent authority to maintain racial segregation and to defend against federal intrusion (Katagiri 2001). The commission was granted extensive investigative powers. The commission was housed in offices adjacent to those of the governor in the state capitol, and the governor served as the ex-officio chairman of the commission. Other ex-officio members were the president of the Mississippi senate, who was vice-chairman of the commission; the attorney general;

and the speaker of the house of representatives. Other members of the commission were appointed by the governor, the president of the senate, or the speaker of the house. The commission also included on its payroll detectives and an undercover network of informants.

The Mississippi Sovereignty Commission, designed to enforce segregation, to spy on those working to end it, and to win the public relations battle, kept detailed records and skirted the edge of legality. Indeed, many believe, and some of the documentation in its files strongly suggests, that the commission indirectly assisted in providing information that led to the abduction of Chaney, Goodman, and Schwerner and in blunting the effectiveness of the subsequent murder investigation. It ceased to receive appropriations in 1973 and was officially dissolved in 1977. After efforts to have the commission's records destroyed met resistance, the final legislation dissolving the commission provided that its records would be turned over to the Mississippi Department of Archives and History and sealed for fifty years (until 2027). A legal battle to open the files was promptly initiated by the American Civil Liberties Union through a class-action suit charging state agencies with illegal surveillance of its citizens. After twenty-two years of legal wrangling, the U.S. district court ruled that those files not involved in litigation should be opened to the public. In 2002 the Mississippi Department of Archives provided photocopies of the commission's records on the agency's Web site (Mississippi State Sovereignty Commission 2004).

These commission files are the primary source for the following story of the racial desegregation of Jackson's hospitals. The commission's records provide a unique window into the private deliberations by which federal officials were accommodated, even in as seemingly a rigid and closed community as Jackson was in the early 1960s. They describe white state leaders struggling to balance the pervasive segregationist political hysteria with their own self-interest. Because it was a rich, complex, and nuanced debate, I quote extensively from the files.

Desegregating Jackson's Hospitals

Hospital desegregation in Jackson entailed three successive waves of concessions. The first wave permitted the construction of a new Veterans Administration hospital, and the second ensured the financial viability of the University of Mississippi's new medical school and hospital. The

final wave of concessions, shaped by the earlier two, permitted the local private hospitals to participate in the Medicare program.

Mississippi's Veterans Battle for a New VA Hospital

In 1956, one of the first challenges faced by the newly formed Mississippi Sovereignty Commission was the Jackson Veterans Administration (VA) Hospital. VA hospitals had been a focus of racially charged political conflict ever since the battle over staffing for the first one constructed for black veterans after World War I in Tuskegee, Alabama (Daniel 1970). The same executive orders (9980 and 9981) by President Harry S. Truman in 1948 ending racial discrimination in federal employment and the segregation of the armed services were applied to the VA hospitals. In the South, Veterans Administration hospitals became small islands of integration. For example, one of the few parts of the Mississippi's twenty-six-mile Gulf Coast beach to which blacks had access in the 1950s was a small section adjacent to the VA hospital (Mason 2000, 52).

Just as it happened elsewhere, the Jackson VA was desegregated uneventfully before the sovereignty commission was formed. In Jackson in 1956, however, the complaints of a white female patient, covered in the local press, stirred demands for action from Jackson's (white) citizens' council. The commission had close ties to the citizens' councils and helped obtain funding for them. Although the white female patient had been placed in the room offering the most privacy the hospital could provide, there were black male patients nearby. Because the hospital admitted few female patients, a separate ward was not feasible. The resulting furor prompted members of the Veterans of Foreign Wars (VFW) to invite Mr. A.W. Woolford, the local VA hospital administrator, to meet with them. According to the minutes of that meeting, included in the commission's files, Woolford explained that because the hospital was federal property, the state had no authority. The policy now was not to allow any federal property to be segregated. Appealing as a fellow southerner raised in the segregated rural South, Woolford explained:

> You know, a sergeant couldn't do anything about the army's pay system. I am on the federal payroll and have to carry out the federal policy or get off the federal payroll. I have no responsibility for federal

> policy. My predecessor, William K. Hines, was raised in Louisiana and Mississippi and felt the same as I. When the hospital was segregated, it amounted to two separate hospitals. When the desegregation orders came, Negroes were put in Corridor B . . . that didn't work. Then they were put in the same ward and segregated and that did not work. If a bed is empty and someone wanted it, it had to be available to him. To keep the races [segregated] together would necessitate either juggling patients or denying admission to sick men. We would spend more time in the purpose of segregation than in the purpose of taking care of the sick. (Mississippi State Sovereignty Commission 2004, 30427–8)

VFW Commander Sidney W. Russell Jr. was troubled about what the VFW's role in the controversy should be. "I am still at a little loss. The VFW has taken a stand as to the benefit of the Veteran, not a case against the government or integration. We have sworn obligations to the best interests of the veteran" (Mississippi State Sovereignty Commission 2004, 30429).

At the same time, Ellis Wright, president of the Jackson citizens' council, had written a letter to all the members of the newly formed sovereignty commission demanding action. Senator Earl Evans Jr., president pro tempore of the senate and a member of the state sovereignty commission, sent a letter on August 2, 1956, to the executive director of the commission. "It is inconceivable, inconsistent and ridiculous for the people of Mississippi to resist by every 'lawful means' integration of the races in one phase of our social life and to accept, without a fight, non-segregation in another and equally vital part of our southern way of life" (Mississippi State Sovereignty Commission 2004, 30437).

The executive director and the state attorney general (also a member of the commission) counseled caution. The VA was a federal institution, and the state had no authority to conduct an investigation, the director noted. The attorney general suggested that it might be possible for the state to provide funds to care for veterans who objected to desegregated facilities in a segregated hospital but that they would still have to report regularly to the veterans' hospital for examinations in order to continue to receive compensation for their disabilities.

The governor and legislature, however, were stuck with a bigger, more symbolic, and politically explosive problem. The Jackson VA hospital was old, overcrowded, and badly in need of replacement. With the urging of Mississippi veterans' groups, the legislature had passed a bill in

1954 donating state land to the VA for the possible construction of a new facility. About $15 million in federal funds had been approved for the project, now in the early planning stages. Responding to the press coverage and the concerns of the Jackson citizens' council and after it became clear that the new hospital would also be fully integrated, State Representative Wilburn Hooker introduced a bill withdrawing the state's offer of land. The white leadership of Mississippi now had to choose between their "southern way of life" and caring for their veterans' medical needs. A local newspaper editorial seemed to sum up the emerging consensus:

> Almost four years of integration at the present Veteran's hospital has not destroyed the historic pattern of social relations in the state. How Rep. Hooker, of Holmes County, figures a new hospital would be more detrimental escapes reasoning. So while we frown on integration, we see nothing less than monumental folly in the Hooker bill and hope, for the sake of every sane Mississippian, that the legislature is of like mind. (Mississippi State Sovereignty Commission 2004, 30496)

Repeating that he was against integration but would rather have the hospital than deny veterans the facility, Governor Johnson let the legislature and the sovereignty commission struggle with the dilemma. The veterans' groups were largely steadfast in their opposition to the bill withdrawing the offer of state land. As one of the veterans' leaders noted:

> The integration controversy has unfortunately overshadowed the real question and that is whether or not our state, by cooperating on this project, is going to give its veterans like ourselves a chance to get adequate treatment without having to go so far from home that our families could never visit us. . . . As far as the integration in the hospital is concerned, it is no problem for the simple reason that the wards are so constructed as to provide each patient his own room or cubicle, which is completely enclosed and affords him as much privacy as he could expect at any hospital, regardless of location. Every patient has the opportunity to associate with any other patient or not, as he sees fit, and there has not been a single unpleasant incident among patients, according to our knowledge. . . . Take it from us, as native Mississippians interested in maintaining segregation, our experience as patients at the VA Hospital here has been such that we do not hesitate to speak out in favor of our state's full-fledged cooperation in getting a new VA facility located here. (Mississippi State Sovereignty Commission 2004, 30564)

In essence, the veterans' groups argued: (1) we need it, (2) it is not "real" desegregation because all patients will have a separate room or cubicle, and (3) we have not sold out. One veterans' group representative did raise some concerns that were later raised by Mississippi politicians about the Medicare program and the effect of desegregation on the patients' mental attitude, and whether it was really fair that "integration be placed ahead of the mental and physical health of the patient" (Mississippi State Sovereignty Commission 2004, 30434). The majority of the leadership, however, fearing the loss of the new facility, was willing to make the necessary concessions. In the end, the concrete benefits offered by the new, federally funded facility trumped the abstract principles of a southern way of life. Accordingly, in 1960 the cornerstone was laid, and the new fully integrated facility in an otherwise fully segregated community opened in 1962.

The Medical School's Campaign to Ensure Federal Funding

The second and more perplexing challenge that the sovereignty commission faced in keeping the hospitals segregated pertained to the University of Mississippi's medical school and its hospital. The University of Mississippi Medical Center in Jackson had been established in 1950 through legislation passed by a one-vote margin. The school and the hospital officially opened in 1955. Unlike the VA, the state of Mississippi clearly had legal authority over its medical school and its hospital. But even though the veterans' loyalties were divided between the segregationist cause and the needs of their own members, there was no such division in the medical center's leadership. Many had been recruited from outside the South, and they were anxious to develop a national reputation. Dr. Robert Q. Marston, a native of Virginia and a former Rhodes scholar who later served as the first director of the regional medical programs, as the director of the National Institutes of Health, and as the president of the University of Florida, was the director and dean of the medical center during this period. Although he never confronted the official state policy formally, he worked deftly to undermine segregation in the medical center (J.D. Bower 2004).

Between 1940 and 1960, the shift in federal funding for medical schools helped Dr. Marston in this effort, as it did other university

medical center directors and medical school deans throughout the South (Starr 1982, 338–63). Before 1940, private funds were the primary source for medical research. But beginning in 1950 until 1960, federal support of medical school research and training grew dramatically. The success in integrating VA and other federal facilities inevitably shifted attention to the federal government's new research and training partners, and the University of Mississippi Medical School, like other southern medical schools, did not want to lose these funds and the prestige associated with them.

In the meantime, the commission had begun receiving complaints through Jackson's citizens' council about the medical center. In 1960 a nurse had complained that the hospital's personnel director and nurses in charge all were from the North and that these nurses had compelled white nurses to work on the "colored" floors and "colored" nurses to work on the white floors. All the elevator operators were black and were allowing black visitors to ride in the same elevators with white visitors. Another informant complained that one of the doctors at the medical center had been lecturing at medical schools around the country and the world and that some of the students from these schools that had visited the medical center in Jackson were black.

The staff member sent to investigate these complaints found that segregation in the medical center was on the verge of collapse (Mississippi State Sovereignty Commission 2004, 38544–50). Since the parking lots were integrated, the investigator felt that new segregated lots should be added. "This will help eliminate the danger of a white lady running into Negroes in the parking lots at night and possibly avoid a bad incident occurring." Even though there were two entrances, one labeled "Colored" and the other labeled "White," both were at the front of the building, and people of both races intermingled in the hospital's corridors. White and colored patients used the same waiting room in the X-ray department. "Since there is only one cobalt machine and all of the X-rays are adjacent to the waiting room. . . . I do not know how the hospital authorities can remedy this congestion of the mixing of the Negroes and Whites, except through extra expansion."

The organization of the obstetric and pediatric services at the hospital was a particular source of concern for the investigator. There was one labor room with eight beds used by both black and white women, and they all used the same four delivery rooms. After their deliveries, the black mothers were placed on a separate floor, but their babies remained on

the same floor in a segregated nursery next to the nursery for the white babies and near where the white mothers were placed. The operating rooms, recovery rooms, and emergency rooms were similarly integrated because space constraints did not permit separate accommodations. On the pediatric floor, children of both races shared a common area and playroom. The black and white children were reportedly not supposed to use the playroom at the same time, although staff admitted that this rule was seldom enforced.

For this investigator, race was more important than insurance or income status. "Although the white patients are mostly charity patients, they should not have to be subjected to constant association in the corridors with Negroes, even though they are not able to pay their hospital expenses. It is bound to be humiliating and embarrassing to them, regardless of their financial status" (Mississippi State Sovereignty Commission 2004, 38547).

The investigator concluded in his report:

> I do believe some steps should be taken to discourage Negroes from pushing themselves into the University Hospital on almost, if not equal terms as the whites, or else in a few more years the University Hospital will wind up a Negro hospital. White people simply are not going to patronize an institution where laxity of segregation is lacking [*sic*] and pay for services on top of that. . . . The University Hospital is a very fine institution and composed of some of the best doctors and instructors in the Nation and is a credit to the State of Mississippi. Mississippi people are proud of the University Hospital, but there are no doubts in my mind but that improvements can be brought about at the University to improve on the creeping integration which is in evidence out there. I am sure it will cost the state extra money, but Mississippi should by all means provide the extra cash needed, to maintain proper segregation at University Hospital. (Mississippi State Sovereignty Commission 2004, 38550)

In other words, if the state wanted to preserve segregation in this highly valued resource, it would have to pay for it.

From the perspective of the sovereignty commission, the situation at the university hospital did not improve. In June 1964 the sovereignty commission sent a detective to the hospital to investigate a report from an informant that "colored employees of the University Hospital were congregating in dressing rooms in the basement of this hospital and other secluded places and were carrying out NAACP programs such as holding private meetings and soliciting membership into the NAACP and

singing so-called freedom songs" (Mississippi State Sovereignty Commission 2004, 38595).

That same month, with the Civil Rights Act of 1964 about to be signed into law, the director of the sovereignty commission sent a detailed memo to Governor Johnson spelling out the options for dealing with the rapidly deteriorating situation at the university hospital. The U.S. Army Medical Research and Development Commission had advised the University of Mississippi Medical Center that it had to comply with the federal executive orders banning segregated facilities. Dr. Marston, dean and director of the medical center, made it clear to the director of the sovereignty commission that the medical center would have to comply with this in order to receive the funds and that this was the first of similar compliance orders from other federal agencies supporting the medical center that affected more than $2.8 million in support. Another $2.5 million in federal funds was pending for construction programs at the medical center. Not counting the federal building funds, these federal funds amounted to nearly 40 percent of the budget for the medical center. In a note to the governor, the director of the sovereignty commission summarized the dilemma:

> It is inconceivable at this time that the State Legislature would be in a position to supplement the appropriation for the Medical Center and replace the federal funds flowing to the Center or available in the future. . . . In a way this leaves us in a somewhat untenable position. We can yield and assure continuance of the funds, which would be against our policies; we could advise the Army [that] we cannot comply with the request and lose the army research grant; we could continue the present segregated facility policies and take a chance that many months or years would transpire before each of the various agencies served a similar notice about the facilities; or we could write off all the federal funds for the Medical Center and seek some method of replacing these funds with either state or private money or both. (Mississippi State Sovereignty Commission 2004: 38600–1)

Perhaps anticipating the governor's concerns about the state budget and economic development in the state, the director recommended a somewhat convoluted set of concessions that might continue the flow of federal dollars: (1) white and colored drinking fountains would be replaced with water receptacles with paper cups for both races, and (2) signs specifying white and colored could be removed from the remaining 24 restrooms, and those too close to working areas for both

whites and colored could be closed, thereby maintaining a system of "voluntary" segregation. In his conclusion, the director recommended a staged approach that would test the extent of the federal commitment to integration:

> It is recommended that the first steps taken be designed to maintain voluntary segregation without the signs identifying race. This step, if handled properly and if administrators of the Center believe it can be adopted and practiced effectively, may forestall the cut-off of federal funds either temporally or perhaps permanently. . . . If this procedure fails and the federal agencies give the Center an ultimatum to "fully desegregate" or face cut-off of funds, we could then reexamine our situation and determine whether to comply in full or seek to make a concerted effort to find other sources to replace these federal funds. (Mississippi State Sovereignty Commission 2004, 38603)

This "voluntary" solution, however, assumed the implicit cooperation of the medical center and its patients in its implementation, which does not appear to have been forthcoming. On August 15, 1964, Dr. Marston sent a cryptic note to the executive secretary of the board of trustees of the state's higher educational system, stating that "certain signs were removed without incident" (Mississippi State Sovereignty Commission 2004, 38616). Marston attached to this note the opinion of the university's attorney on the need for compliance in order to continue to receive federal funding. A copy of the note was promptly forwarded to the director of the sovereignty commission. The final pockets of segregation were eliminated in February 1965 when the University Medical Center publicly announced its intention to comply fully with the Civil Rights Act of 1964. Concrete benefits had again trumped abstract principles, and substituting state for federal funds was apparently never seriously considered.

Medicare and Jackson's Private, Nonprofit Hospitals

Jackson's two private, nonprofit hospitals remained insulated from these earlier battles. In some respects, these facilities served the same function as did the private academies that emerged as a way to circumvent public school desegregation in Jackson and other areas of the South. As previously noted by the sovereignty commission's investigator of the

University Medical Center situation, those people who could pay for their own care could similarly circumvent the publicly funded hospitals by going to private, segregated hospitals. By the time Medicare was implemented, most of the nation's public facilities had been desegregated. Until a court decision in 1964 addressing hospital obligations under the Hill-Burton program and the passage of the 1964 Civil Rights Act (*Simkins v. Moses H. Cone Memorial Hospital* 1964), private hospitals in the United States had remained completely insulated from federal desegregation efforts.

The private, nonprofit hospitals in Jackson also were apparently insulated from the sovereignty commission's oversight. No records for these hospitals appear in the sovereignty commission's files, and only a sketchy account of their desegregation is available from contemporary newspaper accounts. Jackson has two major private, nonprofit hospitals. Baptist Hospital, established in 1911, was the largest and best endowed facility in the Jackson area, and St. Dominic had been constructed in the 1950s. The Dominican sisters had come to Jackson in 1946 to take over the operation of the Jackson Infirmary, an aging structure in need of replacement. They soon began construction of a new 120-bed facility, which was completed in 1954 while they were still searching for $300,000 in additional donations to cover its cost.

From the perspective of the federal officials certifying hospitals for Title VI compliance, the acid test was race-blind room assignment. Mississippi's private hospitals and their congressional representatives followed a two-pronged strategy for blunting the impact of this requirement.

First, they attempted to extract concessions that would weaken it. Senator John Stennis (D, Miss.), chairman of the U.S. Senate Appropriations Committee, introduced in September 1966 an amendment stipulating that

> no funds appropriated by this act shall be used to impose or enforce any requirements on any hospital or medical facility as to an individual beneficiary which are contrary to the beneficiary's physical or mental well being as certified by the attending physician and chief medical officer or acting chief medical officer. (*Congressional Record* 1966, 22975)

The intent was to allow physicians to segregate patients by race on the basis of medical judgment and not have this count against a hospital in terms of Title VI compliance. It offered a loophole potentially large

enough, as Senator Joseph S. Clark Jr. (D, Pa.) observed, "to drive a Mack truck though" (*Congressional Record* 1966, 22976).

The amendment passed in the Senate but was deleted in conference, though not before Senator Stennis had extracted from Secretary John Gardner a promise in writing to agree to these arrangements. This understanding was challenged in a federal court decision the following year that stated that race could not be a factor under any circumstances in the assignment, classification, or treatment of patients (*Cypress v. Newport News* 1967). Judge Simon Sobeloff, who wrote the opinion, was faced with a case in which a hospital's medical staff had discriminated against highly qualified black physicians by rejecting their applications for privileges. He was clear in his discussions with his colleagues that allowing such discretion would be equivalent to letting a "fox guard the hen coop" (Sobeloff 1967). Although Mississippi's day-to-day operations had to be discreet and selective, hospitals probably continued to operate with some leeway in regard to room assignments.

The second prong of the strategy to resist desegregating room accommodations that many hospitals in Mississippi and elsewhere adopted was to build around this requirement. In Greenville, Mississippi, for example, the hospitals converted their semiprivate rooms to private rooms (Pohl 2000, 115). Such solutions created pressures for expansion and the construction of new facilities. Medicare and Medicaid, however, covered their share of the costs associated with such construction or renovation.

Jackson's two private hospitals followed different paths in accommodating the Title VI requirements for Medicare funding, reflecting their governance structures. As part of a hospital system based in Springfield, Illinois, the new St. Dominic's did not face the same constraints that might have been imposed by a local board composed only of Mississippi residents. It complied with the requirements related to Title VI of the Civil Rights Act of 1964 and received Medicare funding with the beginning of that program in July 1966. It was not a difficult business decision to make. Medicare reimbursement in the early years of the program was generous, based on cost and including payments to cover the costs of constructing and renovating hospital facilities. Combined with Medicaid, the total government payments requiring Title VI compliance typically accounted for more than 60 percent of a general hospital's income.

Baptist Hospital, however, which was governed by white Mississippians, refused to comply and continued to operate as a segregated facility

without Medicare funding. Its medical staff and managers no doubt watched with growing frustration as St. Dominic's share of the local market expanded and its own financial position deteriorated. In 1969 St. Dominic's broke ground for an expansion that would double its size to more than 400 beds. Only then did the board of Baptist Hospital, one of the last large general hospitals to remain outside the Medicare program, relent. In a nine-to-four vote on April 9, 1969, the board agreed to begin talking to federal officials about how Baptist had to desegregate in order to be certified for Medicare funding (*Clarion-Ledger* 1969). All of Jackson's hospitals were now officially desegregated.

Discussion and Conclusions

The desegregation of hospitals in Jackson described here offers three insights into a poorly documented aspect of a complex and turbulent era of change.

First, even in the most fortified bastion of defense against desegregation, it is remarkable how shallow and largely symbolic the support for segregation was, at least in regard to health care funding. As one observer of the history of desegregation in general noted, there is "always something more important than race" (Zinn 1995, 92). For the veterans, getting a new hospital was more important. For the state officials publicly committed to preserving segregation, preventing the loss of federal funding for their medical school took precedent. Even for the private hospital most stubbornly committed to blocking federal intrusion, financial and competitive advantages eventually overcame resistance.

The seeming ease in overcoming resistance to hospital desegregation in Jackson can be viewed either optimistically or pessimistically. The optimistic view is that obtaining and being able to provide good health care was ultimately more important than race. As evidenced by the description in the sovereignty commission's files of the operation of the VA and medical center hospitals, segregation was a costly encumbrance with which full compliance was impossible. That is, for complete racial segregation, much of the staff, space, and equipment would have had to have been duplicated. In the process, these facilities would have turned away persons needing care while staff, beds, and equipment stood idle. The more pessimistic view is that preserving power and control was more important than race. In health care, segregation was important only if

there was a way to pay for it. Race was still an emotional symbol that politicians could continue to manipulate. Perhaps, in a more disguised fashion, it still is.

The second insight offered by the desegregation of Jackson's hospitals is the central role of the federal government. Its success in integrating the VA and the medical center hospitals in a city as segregated as Jackson tested the resistance that federal officials could expect from a more massive effort to use the Medicare program to force the desegregation of all hospitals. The early successes no doubt added to federal officials' confidence that they could make Title VI compliance in the implementation of the Medicare program stick, despite the warnings from some experts.

Finally, many of the changes brought about by federal efforts were strikingly limited, incomplete, and cosmetic. In this respect, the adaptation and resistance in Jackson mirrored that in the rest of the country. The veterans' argument that the desegregation of the VA hospital was irrelevant because the patients had private cubicles or rooms anticipated the massive conversions to private rooms, particularly in racially diverse service areas ironically subsidized by federal Medicare funds. Indeed, when the private hospitals in Mississippi integrated, many converted to single-patient occupancy (Pohl 2000, 132). Similar conversions took place in both the North and the South in areas where there was a large African American population (D.B. Smith 1999, 229–33). The races were physically separated further by the expansion of separate inpatient facilities in suburban areas and of off-site ambulatory facilities.

The desegregation of Jackson's hospitals has possibly troubling implications for current efforts to eliminate disparities in treatment. Although federal dollars continue to play a powerful role in shaping our health care delivery system, that role has changed. Indeed, in some respects those changes have created financial incentives for hospitals and other providers that echo those that existed before the federal offensive to end segregation.

At that time, hospitals resisted desegregation in part because they feared the financial impact of the flight of white, privately insured patients to facilities that remained segregated. The requirement of Title VI certification for all participating hospitals and the generous cost-based reimbursement provided with the introduction of Medicare gave hospitals a strong and unambiguous financial incentive to integrate their facilities and ensure equal access.

The federal health care programs' current emphasis on cost containment, however, could alter demand and supply in a way that encourages disparities in treatment (Rice 2002). In the early years of the program, Medicare and Medicaid payments to hospitals and physicians were generous and encouraged the expansion of services, ensuring more equal treatment by income and race. But when cost controls reduce Medicare or Medicaid payments to hospitals below cost or below the payments of those with private insurance, hospitals have an incentive to be more selective about where to expand and contract their services. A hospital has a better chance of surviving financially if it increases its admissions of privately insured patients and reduces its admissions of Medicaid and uninsured patients. This can translate into reducing services in poorer and predominantly minority communities and expanding services in more affluent and predominantly white suburban areas.

Not only do the current financial incentives faced by hospitals have the potential to increase disparities, but they also may resegregate care. For example, the number of hospitals in the Philadelphia metropolitan area offering cardiac catheterization and coronary bypass surgery doubled after certificate-of-need restrictions were eliminated, but the total volume of procedures in the region remained essentially the same. Since all the new providers of these services are located in affluent, predominantly white suburbs, this has tended to resegregate such care. In addition, since the cost per procedure for an individual provider usually falls and the quality rises with volume, the result has been, arguably, higher cost and lower quality for everyone (D.B. Smith 2005).

In a similar move, the University of Mississippi Medical Center has converted a largely abandoned shopping mall close to the black community into a "medical mall" for its clinics. One side effect of this relocation may have been the partial resegregation of patients who at least used to cross paths in the hospital corridors even before the hospital was fully desegregated. For whatever the benefits of this development, it may help address the concern, noted by the sovereignty commission investigator more than 40 years ago, of reducing the privately paying white flight from the main hospital.

Most troubling is the apparent failure to learn the simple basic lesson from this past. As illustrated by the experiences of Jackson's VA and the university's medical center, segregation produces more expensive and lower quality care. The integration of Jackson's VA hospital offered better access and more efficiencies in caring for both black and

white veterans. The ineffective segregation of patients at the University Medical Center was a costly encumbrance that even archsegregationists were unwilling to invest in refining. In the provision of health care, greater volume generally improves efficiency and outcomes. Separation, whether it results from Jim Crow laws or "voluntary choice," reduces volume. We do better when we work together.

Notwithstanding these warnings about current federal directions in financing, what was accomplished was remarkable. Mississippi was transformed. Gross racial disparities in access to hospital care and to physicians were dramatically reduced. Hospitals in Mississippi now rank as the fourth most racially integrated in the nation (D.B. Smith 1998). Black/white disparities in infant mortality and age-adjusted death rates are now significantly lower in Mississippi than they are in the United States as a whole (National Center for Health Statistics 2004, 126, 134). Politically, while much of the old power structure and conservative orientation have been preserved, Mississippi has a higher proportion of black elected officials than any other state in the union. Jackson now has a black mayor and has been rated as one of the most livable cities in the United States. Certainly in opening its segregationist past for review, Mississippi has taken a major step in reconciliation.

Symbolic of all these changes is the Mississippi state fair, hosted on the outskirts of Jackson. On the bluff overlooking the fairgrounds is the recently completed William F. Winter Building, which houses Mississippi's archives and history collection, including the files used in this article. Governor Winter helped end some of the disparities in public education in Mississippi that had persisted decades after the civil rights era.

Before the civil rights era, Jackson hosted two state fairs, one "white" and the other "colored." In 1963 the livestock pavilions on the fair grounds were converted into hog wire–enclosed compounds to hold black protesters because so many had been arrested the jail had run out of space. Mississippi now has one state fair. At the 2004 state fair, its troubled past was relegated to a single booth run by the Mississippi-based nationalist movement. The booth's featured attraction was supposed to have been Edgar Ray Killen, now 80, an alleged former Ku Klux Klan leader accused of orchestrating the 1964 murders of James Chaney, Andrew Goodman, and Michael Schwerner. However, in the storm of protest that followed local newspaper coverage, these plans were canceled (Clark 2004). More than 40 years after their deaths, Mr. Killen's trial for their murder is now scheduled to begin in June 2005.

Perhaps beneath the regrets about the past in many Mississippi blues songs is hope. To paraphrase Mississippi's native son William Faulkner, the hope is that the citizens of Jackson and this nation, black and white, will not just endure, they will prevail.

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