Segregation and Discrimination in Medical Care in the United States

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A surveyor reports some heartening progress in the integration of Negro personnel in public health administration and medical services. He makes some recommendations for accelerating the process.

The practice of segregation and discrimination in the United States is not the particular province of any section of this country since it may be found North or South; nor has it been directed at any one specific group of the population since various racial, religious, and nationality groups have felt, or are experiencing, the effects of these practices. The writer is most conversant with segregation and discrimination as they apply to the Negro and therefore this paper will be concerned with this group in relationship to health and medical care.

Decades of Segregation and Discrimination (1930–1939 and 1940–1949)

The decade of 1930–1939 was characterized by patterns of segregation and discrimination which had been well crystallized during previous years. Segregation and discrimination had the sanction of custom and law in the South; in the North segregation, though not as overtly practiced in governmental establishments, was readily found in private agencies and was tacitly practiced and accepted. The health and medical care picture of the Negro was certainly a dismal one and a few examples will suffice to give the temper and mood of the times.

The mortality and morbidity rates of the Negro in this decade when compared to those of white individuals were disproportionately higher than at present, but health facilities continued to be allocated to them in terms of their proportion in the population rather than in terms of needs.[1] The number of Negro professional students reached its lowest ebb during the decade. For example, during the school year 1935–1936[2] there was a total of 369 medical students enrolled throughout the United States. Of these, 346 were registered at Howard and Meharry Medical Colleges, predominantly Negro schools, and the remaining 53 were enrolled in 23 northern schools. Internships were available, with the exception of one or two places, only in Negro hospitals while residencies were even fewer. Professional societies for doctors, nurses, dentists, and pharmacists did not admit Negroes in the South, and very few Negroes were found in those of the North.

The employment of Negro professional personnel in health and medical care agencies left much to be desired. Governmental and nongovernmental institutions at the federal, state, and local levels provided few opportunities for the employment of Negro professional personnel with the possible exception of nurses. The Public Health Service, for instance, in 1939 employed 8,000 professional workers and yet not more than 25 of these were Negroes and only four were on a full-time status.[3] At the state level in 1930, of seven states—Arkansas, Delaware, Kentucky, Mississippi, North Carolina, West Virginia, and Alabama—

only one employed a part-time Negro physician, three employed 29 nurses but none employed Negro dentists or dental hygienists. The same situation obtained locally.[4]

Hospital services for Negroes in 1930–1939 were at the lowest possible level. The availability of hospital beds for them, particularly in the South, was minimal as seen in the often-quoted survey of Mississippi.[5] In addition to inadequacy in numbers there were marked qualitative differences in the South. As a result many proprietary Negro hospitals made their appearance and by 1930 there were some 183 such hospitals of which about 20 were approved for intern training.[6]

Voluntary health agencies and foundations, with the exception of the Rockefeller Foundation indirectly, and the Julius Rosenwald Fund, the National Tuberculosis Association, and the American Social Hygiene Association directly, had shown little or no concern about the health of the Negro. The report of the Committee on the Costs of Medical Care, published in 1933, recommended provision of medical care and following it group hospital insurance plans began to flourish, but this in no way touched the Negro population nor were attempts made to attract him.

The first seven or eight years of the decade of 1940–1949 were not too different from the previous ones, except that there was a crescendo of voices from many quarters calling attention to the injustices and ill effects of segregation and discrimination and the need to do something about it. The National Urban League Community Relations Project initiated in 13 northern and southern cities in 1945–1946 documented conditions as already described.[7] Cobb[8] in his comprehensive report of 1947 also called attention to the inequalities and adverse pattern existing through the land. The Report of the Commission on Hospital Care also of 1947[9] addressed itself to the provision of hospital service and the quality of care being received by Negroes and made strong recommendations for their improvement. Numerous other reports, both state and local, made their appearance between 1940 and 1948.

This increased concern about the Negro in the latter part of the decade in question grew from changes in social attitudes and the emergence of this country as an international power after World War II—which made it necessary for her to make friends with, and influence, nations of colored people. The full impact of this was not noted until the next decade but tell-tale signs could be seen in the last half of this decennium. A few may be mentioned. In 1946 the American Nurses' Association established a direct national membership for nurses who were deprived of membership in their county societies. The Baltimore City Medical Society in Maryland opened its doors to Negro doctors in 1948, and this was followed by similar actions in 1949 by Oklahoma and Missouri. The University of Arkansas in 1948 became the first of the 26 medical schools of the South to admit a Negro student. The Hospital Survey and Construction Act which became law in 1947 contained an anti-discrimination clause, though watered down by providing an alternative to satisfy the segregated pattern of the South.

These then were some of the developments which were undermining the foundations of segregation and discrimination in medical care and which heralded the advent of greater integration in the present.

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Decade of Integration (1950 to Date)

The decade of 1950 is admittedly that of integration buttressed by the Supreme Court decision of May 17, 1954, on education. Our concern today therefore is how far we are in the first half of this period on the road to integration in health and medical care in the United States. For purposes of accuracy and completeness it would have been desirable to obtain information by personal visits to selected states. This being impossible, it was decided to inquire by means of the questionnaire method into the following four facets of health and medical care: (a) medical schools; (b) medical societies in the South; (c) Blue Cross-Blue Shield plans; and (d) hospitals and health agencies.

It is fully realized that the questionnaire method has many pitfalls, but the results in these instances may give us an indication of the trends.

Medical Schools—Questionnaires were sent to each of the 74 four-year medical schools in the United States requesting information about their total enrollments and those of Negro students for the year 1955–1956. Of the 49 schools in the North and 25 in the South, 43 and 23, respectively, replied, a total of 66. The total enrollment however for each of the eight schools that did not answer was obtained from a current Journal of the American Medical Association.[10]

The 49 medical schools in the North had a total enrollment of approximately 18,500 students as shown in Table 1. Of the 43 schools that replied, 33 had an enrollment of 171 Negro students. When contrasted with the year 1947–1948 [11] it is found that the number of schools had increased by six, or 19 per cent, and the number of students by 78, or 84 per cent. Although there has been improvement in the North, the proportion of Negro students to total enrollment is woefully small. Even when the enrollment of the six schools that did not respond is subtracted from the total thus reducing it to 15,843 students, the figure of 171 Negro students is barely over 1 per cent of the total. The state of Michigan has the best experience with about 2.5 per cent. It is significant that this state has maintained this leadership for many years. It is well to keep this in mind when emphasis is placed on the lack of qualified Negro applicants.

The 25 medical schools in the South had a total enrollment of 9,103 students (Table 2). Of the 23 schools that reported, 10 including Howard and Meharry Medical Colleges, had 561

Table 1—Distribution of Medical Students in Northern States 1947–1948 and 1955–1956

States	Enrollment of Medical Students		
	1947–1948*	1955–1956	
	Negro	Total	Negro
California	11	1,341	13†
Colorado	0	294	2
Connecticut	3	320	1
Illinois	8	2,043	16
Indiana	4	585	15
Iowa	1	441	3
Kansas	0	427	8
Massachusetts	8	1,255	10†
Michigan	17	1,039	26
Minnesota	0	480	0
Missouri	0	846	4
Nebraska	1	629	12
New York	23	3,173	18‡
Ohio	6	1,228	21
Oregon	1	295	0
Pennsylvania	10	2,623	21†
Utah	0	206	0
Vermont	0	179	0
Washington	0	288	1
Wisconsin	0	714	0
Total	93	18,406	171

* Johnson, J. L. Op. cit.
† One school not included.
‡ Three schools not included.

Table 2—Distribution of Medical Students in Southern States 1947–1948 and 1955–1956

States	Enrollment of Medical Students		
	1947–1948*	1955–1956	
	Negro	Total	Negro
Alabama	0	310	0
Arkansas	0	315	8
Washington, D. C.	264	1,101	258
Georgia	0	640	0
Kentucky	0	379	5
Louisiana	0	953	0
Maryland	0	674	3
North Carolina	0	763	1†
Oklahoma	0	377	5
South Carolina	0	296	0
Tennessee	231	1,267	260†
Texas	0	1,375	11
Virginia	0	653	10
Total	495	9,103	561

* Johnson, J. L. Op. cit.
† One school not included.

Negro students. When contrasted with 1947–1948 this becomes one of the significant achievements of this decade. In that year no southern medical school other than Howard and Meharry admitted Negroes; today eight of these schools have lowered their barriers and have an enrollment of 43 Negro students. Of the 13 states and the District of Columbia with medical schools only four, Alabama, Georgia, Louisiana, and South Carolina, are without Negro enrollees. It is to be emphasized, however, that even though there has been this progressive step, the increase in the number of Negro students between 1947–1948 and 1955–1956 has only been 13 per cent and the 43 students in the eight medical schools constitute about 1 per cent of the total enrollment of 4,225 students, thus paralleling the ratio in northern schools. It is of interest to note that Arkansas, which was the first to admit Negroes to its medical school, continues to maintain the highest ratio for this group.

Medical Societies in the South—The relationship of the Negro physician to organized medicine in the South has been of much concern to all individuals interested in medical care. Questionnaires were sent to the executives of state and county medical societies listed in a 1954 roster.[12] This included 16 states, the District of Columbia, and 32 counties. Of these, 15 states, the District of Columbia, and 27 counties replied. All the 15 states, with the exception of Louisiana, now admit Negro physicians and had thus far received 197 memberships. Of the 27 counties which were distributed in all of the southern states except North Carolina, 23 admit Negroes. The four counties that do not admit Negroes are scattered in South Carolina, Tennessee, Texas, and Virginia. Thus on the basis of these data, even though information was not received from North Carolina, it may be said that all southern states with the exception of Louisiana and possibly North Carolina have opened their doors to Negro physicians. This has been another achievement in the area of race relations in medical and health care.

Two regrettable situations must, however, be noted. In the first place, although state medical societies have lowered these barriers, there are county medical societies which continue to barricade themselves against Negro membership. Second, the number of Negro doctors in the 15 state medical societies, the District of Columbia, and the 23 counties bespeaks not too well for their interest. This is well seen in a community like the District of Columbia where there are over 200 Negro physicians and only 61, or less than one-third, have thus far joined the medical society. The same situation has also been recently reported for New York City.[13] The Negro physician has a responsi-

bility in this area which he cannot lightly ignore.

A word should be said about Negro dentists and dental societies in the South, although this was not investigated. All available information indicates that at the present time not one state or county dental society is opened to Negro dentists. Since Negro nurses and pharmacists are able to join their national professional societies without going through their local units, and the doors have been opened to Negro physicians, the Negro dentist in the South remains the only member of a major health profession who still is barred from even joining his national organization, the American Dental Association.

Blue Cross and Blue Shield Plans—An effort was made to study Blue Cross and Blue Shield Plans as they relate to Negroes, but this was not too productive. The 68 Blue Shield Plans in the United States of which 41 are in the North and 27 in the South were addressed. Of these, 62 replied—37 and 25 in the North and South, respectively. All reported that membership was not separated according to race and therefore accurate figures could not be given. However, some estimates were offered. The 11 southern plans gave estimates ranging from 1 to 20 per cent of total membership. Only four of the plans gave figures between 10 and 20 per cent, while the others placed the values at 7 per cent or below.

In the North only seven plans gave an estimate, varying from one-half to 15 per cent of the total membership. All the plans (North and South, with the exception of two in the South) reported that Negro physicians if they are available are participating doctors in the surgical plans. The lack of Negro physicians was present in four of the northern and two of the southern cities replying. The major difficulties experienced by the plans as far as Negroes were concerned had to do with the cost as it related to individual memberships; the lack of appreciation for hospital care; the inadequacy of facilities; and the lack of staff privileges for physicians. It would appear that these will have to be resolved if the Negro is to receive fuller benefits from these plans.

Hospitals and Health Agencies—An inquiry into segregation and discriminatory practices in hospitals and health agencies by sending questionnaires to each establishment is fraught with obvious difficulties. Therefore, the writer took advantage of his association with the National Urban League and sent questionnaires covering hospitals, health departments, and miscellaneous matters to each of its affiliates in the United States. The staff members of each of the local Urban Leagues work closely with the community and its agencies and therefore were in a position to act as an alter ego for the investigator and thus provide more accurate information.

A questionnaire was sent to each of 60 cities, 45 in the North and 15 in the South, in which Urban League chapters are located. Filled questionnaires were received from 31 cities, of which 23 were in the North and eight in the South. The 23 northern cities are located in 15 states with a total of almost nine million persons of whom approximately 860,000 are Negroes. The range of the total population and that of the Negro varies from 25,000 to 975,000 and from 2,100 to 160,000, respectively. The eight southern cities are scattered in seven states with a little over three million persons, of whom approximately 760,000 are Negroes. The range of the total population and that of the Negro is from 87,800 to 900,000 and from 20,000 to 260,000, respectively. This sample, therefore, is deficient in two respects: namely, the absence of the larger metropolitan areas and the small number of southern cities. Nevertheless, certain trends may be observed.

Hospitals: The 31 cities (as seen in

Table 3—Number of Hospitals According to Race and Type

Area	Number of Cities	Number of Hospitals			Type of Hospitals	
		Total	White	Negro	General	Special
North	23	344	338	6	256	88
South	8	107	96	11	69	38
Total	31	451	434	17	325	126

Table 3) are served by a total of 451 hospitals of which 434 are operated by white persons and 17 by Negroes. Approximately 70 per cent of the hospitals both North and South are considered general in type. Integrated practices in the general hospitals are revealing as shown in Table 4 and 5. In the North 82.5 per cent of the general hospitals offer patient care on an integrated basis. Although the percentage for the North appears to be extremely good for these cities it may not reflect the true picture for the country as a whole. In the South only four or 5.8 per cent of the 69 hospitals admit Negroes without restrictions. Of the remaining 65 general hospitals approximately half have segregated wards, about one-third do not admit any Negroes and the rest have modifications of established segregated or discriminatory patterns. The special hospitals show a similar pattern both North and South.

The situation is somewhat different when staff affiliations are analyzed in Table 5. It is noted that opportunities for internships, residencies, courtesy, and attending staff privileges are available both in the North and South. However, in the North the number of hospitals that have opened their doors vary from 24 or 10 per cent of the total, in the case of residencies to 50 or about 20 per cent for membership on the active staff. These figures in no way approximate the 82.5 per cent of the northern hospitals that serve the Negro on an integrated basis. In the South the figures are four or 5.8 per cent in the case of internships and residencies and 16 or 23 per cent in the case of staff privileges. The larger percentage of hospitals in the latter category is due to the wider use of segregated units which facilitates the appointment of Negro physicians. In terms of special hospitals, the ones in the North follow the pattern for the general hospitals, but of the 38 special institutions in the South only one had a Negro on its staff in the capacity of an attending member. Thus it would appear from this brief purview that in the South segregation as a pattern in hospital services still is widespread. Also discriminatory practices in reference to staff affiliations for Negro doctors are prevalent in both the North and South.

Table 4—Number of General Hospitals with Integration of Patients

Area	No. of Cities	No. of General Hospitals	Integrated Hospitals	
			No.	Per cent
North	23	256	211	82.5
South	8	69	4	5.8
Total	31	325	215	66.2

Health Agencies: Health departments and voluntary health agencies were also the subject of inquiry in the Urban League questionnaires. Of the 23 cities in the North, 20 reported that the services offered by health departments are on a nonsegregated basis. The re-

Table 5—Number of General Hospitals with Negro Medical Staff Members

Area	No. of General Hospitals	No. of Hospitals with Negro Physicians			
		Interns	Residents	Courtesy	Active
North	256	31	24	46	50
South	69	4	4	6	16
Total	325	35	28	52	66

maining three stated that segregation is practiced in some facilities. Thirteen of the 23 cities reported that Negro professional personnel are employed in these official health agencies. Of the eight cities in the South, six reported segregated and two integrated services. All eight health departments employ Negro professional personnel. It would appear from this that the segregated pattern in official health agencies, which has been so prevalent in the South, still persists and possibly is one that has shown the least progress toward integration. This should be of concern to the American Public Health Association and the Conference of State and Territorial Health Officers.

The 20 northern cities answering the questions on voluntary health agencies reported a total of 200 such organizations. However, of these agencies only 33 or 16.5 per cent employ Negroes and only 33—but not the same as in the previous figure—have Negroes on their governing boards. In the eight southern cities there were 58 such organizations with 13 or 22 per cent employing Negroes and 12 having Negro representation. There would appear to be need for an opportunity for greater participation of the Negro community in the operation and formulation of policies of nonofficial health agencies.

Summary

This purview of the past 25 years, even though inadequate in a number of areas, shows that significant progress toward integration—some outstanding—has taken place. The barriers of segregation and discrimination in health and medical care have crumbled in many places. The admission of Negro medical students in southern schools, the acceptance of Negro physicians in southern medical societies, the wider degree of integration in northern hospitals, the increased opportunities for intern and residency training support this contention. However, there are still sizable islands of segregation and discrimination. These are seen in health departments throughout many areas of the South, the separate and inadequate hospital facilities for Negroes in the South, the reluctance in appointing Negro physicians to hospital staffs in the North, the resistance to Negro membership of many southern county medical societies, the attitude of voluntary health agencies which prevents Negroes from sharing in the formulation of policies and the complete block to membership in local dental societies in the South. All these and more must be eradicated if we are to achieve complete integration by the end of this decade.

Recommendations

This study suggests certain recommendations which should be helpful in achieving the desired end and these may be briefly summarized.

Federal health acts passed by Congress should contain nondiscriminatory

clauses in order to safeguard the allocation of such grants. Any federal legislation, such as the Hospital Construction Act, which makes it possible for grants to be given to states that maintain separate facilities for racial groups should be amended by having such clauses stricken from the act.

State legislatures should consider legislation to end discriminatory practices in hospitals and other health facilities. This has already been achieved in Illinois. Just as in education it may be necessary to pursue this matter through the various courts until it reaches the Supreme Court.

Federal health agencies that have the responsibility of administering grants to states should now establish administrative policies which would prevent states with separate facilities from receiving such grants. Philanthropic foundations should cease to make grants for health and medical care to states which maintain separate facilities and services for racial groups.

Health agencies and organizations have a responsibility to go on record in favor of integrated facilities and the abolition of discriminatory practices, since the achievement of this will be translated in the reduction of morbidity and mortality and an increase in the average expectation of life of the Negro. Segregation and discrimination are environmental factors and are just as damaging to health as water pollution, unpasteurized milk or smog. The American Public Health Association and certainly this Section have a responsibility in this area.

Every public health worker, whether in the North or South, ought not to accept the patterns of his community as sacrosanct, but rather should help set the wheels in motion whereby responsible community leaders can come together and work out solutions for the improvement of the health of every single individual in that community. The admonition of Parran, "We have no defense unless all are safe among us" [14] is still important today. The achievement of this will require more than routine adherence to accepted public health practices.

Integration in health and medical care is not only basic to the future of the Negro but also to that of this country. Henry Cabot Lodge, Jr., at a meeting on job discrimination recently held in Washington said: "Any shortcomings we have at home in the field of civil rights and race relations hurt us abroad. Conversely any progress we make in these matters help us abroad." [15]

REFERENCES

1. Cornely, Paul B. Trend in Public Health Activities Among Negroes in 96 Southern Counties. A.J.P.H. 32:1117–1124 (Oct.), 1942.
2. Council on Medical Education and Hospitals. Medical Education in the U. S. and Canada. J.A.M.A. 107, 9:661–692 (Aug. 29), 1936.
3. Cornely, Paul B. Trends in Public Health Activities Among Negroes During the Period 1930–1939. Julius Rosenwald Fund, Chicago, Ill., 1940. (Unpublished report.)
4. ———. Trends in Public Health Activities Among Negroes in 96 Southern Counties During the Period 1930–1939. I. The Employment of Negro Professional Personnel. J. Nat. M. A. 34:1:3–11 (Jan.), 1942.
5. Council on Medical Education and Hospitals. Hospitals and Medical Care in Mississippi. J.A.M.A. 112:2317–2332 (June 3), 1939.
6. ———. Investigation of Negro Hospitals. J.A.M.A. 92:1375–1376 (Apr. 20), 1929.
7. Cornely, Paul B. Race Relations in Community Health Organization. A.J.P.H. 36:984–992 (Sept.), 1946.
8. Cobb, W. M. Medical Care and the Plight of the Negro. New York: NAACP, 1947.
9. Commission on Hospital Care. Hospital Care in the U. S. New York: Commonwealth Fund, 1947.
10. Council on Medical Education and Hospitals. Medical Education in the U. S. and Canada. J.A.M.A. 159:563–606 (Oct. 8), 1955.
11. Johnson, J. L. The Supply of Negro Health Personnel—Physicians. J. Negro Educ. 18, 3:346–356 (Summer), 1949.
12. Council on Medical Service. Roster of Executives of State Medical Associations and County Medical Societies. Chicago, Ill.: American Medical Association.
13. Murray, Peter M. The Status of the Negro Physician in New York State. New York State J. Med. 155:2980–2982 (Oct. 15), 1955.
14. Parran, Thomas. No Defense for Any of Us. Survey Graphic 27:197–202 (Apr.), 1938.
15. As reported in the Washington Evening Star, October 26, 1955.