

Inequality and African-American Health

HOW
RACIAL
DISPARITIES
CREATE
SICKNESS

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TWO

Sickness in slavery and freedom

The health deficit that exists among African Americans and is perpetuated by a racialized social system can more broadly be understood by placing it within historical context, especially the centuries of slavery and racial segregation that black people endured. Most Africans were brought to the US involuntarily, enslaved, exposed to dismal diets and living conditions, and subjected to brutal punishment and mechanisms of social control. These harsh conditions contributed to the health maladies that were common among most immigrants to the New World, such as the widespread exposure to infectious diseases that usually could not be reliably controlled by medical interventions.

Emancipation proved an even greater health disaster for the formerly enslaved, as the freed men and women lost whatever value they previously held as the property of slave owners and entered a society that had made few provisions for the transition of more than four million people from slavery to freedom. The question of whether African Americans would be integrated into the US population was not decided until 1896, when the Supreme Court legalized racial segregation with a "separate but equal" doctrine. Racial segregation remained legal until the civil rights movement of the 1960s, and made it difficult for African Americans to obtain adequate medical care, an issue compounded by the fact that Blacks had at best restricted access to medical education.

The ascendancy of modern scientific medicine, already underway by the mid-1800s, also had significant consequences for African Americans. Enslaved black people were often used for medical experimentation and, once slavery was abolished, the medical profession promoted theories of black inferiority through a form of scientific racism that argued the health issues facing African Americans

were due to their inherent moral, biological, and cultural deficiencies. For the bulk of the 20th century a racially-based dual health care system offered African Americans substandard care, often in overcrowded segregated hospital wards.

Notable histories on the rise of modern scientific medicine rarely include much about black health care during or after slavery, or the struggle of African Americans to obtain health care and become health care professionals. This chapter helps write that history into the story of the US health care system. I start with an examination of health and health issues among enslaved black Africans in colonial America, and then explore how emancipation affected their health and access to medical care. I contend that the health deficit of African Americans today, along with some of their health behaviors and decisions, are deeply rooted in a medical care system that promoted scientific racism, used African Americans for medical experiments, denied Blacks adequate medical care, and excluded them from the practice of medicine. This chapter also highlights the agency of African Americans in pursuing justice in medical care.

Health of black Africans in early America

The health and health care of the black Africans brought to what later became America is best understood within the broader context of colonial life in the 1600s. Life for most of the early colonists was characterized by a perilous journey of immigration from Europe to the New World and the hardships of constructing life on unsettled frontiers. Many early English immigrants were motivated by the hope of greater religious freedom, but were also escaping a rapidly developing industrial economy in Europe, which displaced workers and created dire living conditions. Still, the first White settlers in the New World faced almost insurmountable obstacles to survival, such as malnutrition, starvation, and sickness (Shryock, 1966). The summers brought high rates of diphtheria, smallpox, and malaria—especially as communities grew in size—and deaths from respiratory illnesses were common in the winter. Even in sparsely settled areas, sicknesses were prolific and a constant source of concern; indeed, the diaries and writings of early colonists are filled with concerns about health and healing (Savitt, 1978, 2005). Infectious diseases and an absence of effective medical care made sickness, infant and maternal mortality, and early death common.

Black Africans were among the earliest settlers to come to North America from abroad: 20 enslaved Blacks were brought to the shores of Jamestown, Virginia in 1619. Slavery already existed in Spain and England, but in the colonies it took most of the 17th century to clearly define chattel slavery, clarify the legal status of enslaved Blacks, and have their treatment codified into law (Byrd and Clayton, 2000). Once complete, that process had instituted perpetual and hereditary servitude, stripped enslaved people of rights over their person or property, and defined them as property. So in addition to being exposed to the diseases prevalent among Whites, the health of enslaved Blacks was further jeopardized by their racial status. As Byrd and Clayton (2000) have explained, slaves entered North America with substantial health deficits, often stemming from being captured, held in slave castles, surviving the Middle Passage, and in some cases enduring up to a three-year “breaking in” process in the New World. Conservative estimates are that the mortality rate among Blacks—from their sale or capture in Africa to their entry into slavery—was about 50 percent, though some argue it was much higher.

Slavery thrived for more than two-and-a-half centuries in the United States, and the unpaid labor of slaves played a crucial role in building the wealth of the nation (Baptist, 2014). But it also contributed inestimably to poor health and the dismal living conditions of black people. Beyond the common travails of sickness experienced by all early Americans, the health of slaves was jeopardized further by poor housing, lack of sanitation, and work schedules that often required them to work from dawn to dusk practically every day of the year. Slave quarters were typically filthy, often infested with huge numbers of pests and parasites, and enslaved Blacks were given very little time or resources for bathing, or washing their hair, clothing, or beds (Savitt, 1978; Byrd and Clayton, 2000). Nearly all children and many adults lacked shoes or sufficient clothing. It was not uncommon for younger children to be naked (Savitt, 1978) and field workers so scantily clad that they tried to hide when strangers approached (Owens, 1976). Cultivating crops like tobacco, rice, and sugar cane had especially adverse health consequences, and the diets of slaves, consisting largely of pork, corn, and cornmeal, contributed to poor health (Savitt, 1978). Eating soured and spoiled food was a constant source of sickness, especially among Blacks owned by small slave owners with only a few slaves.

Historians have documented that infectious diseases like body lice, ringworm, and bedbugs were especially common among slaves, as were more life-threatening respiratory illnesses. Colds, flu, diarrhea, and pneumonia were prolific sources of sickness and death, and malarial

fevers (for example, typhoid, yellow, and scarlet) were especially dreaded and likely to lead to death (Owens, 1976). Sexually transmitted diseases (STDs) were prevalent among the poor regardless of race, but more so among enslaved Africans. Casual sexual activity among slaves was often encouraged, as it increased fertility and weakened family ties. Byrd and Clayton reported that slave quarters were incubators for STDs, especially syphilis, which was sometimes congenital. The standard treatment of STDs was costly, relatively ineffective, and unavailable to the poor, especially enslaved Blacks.

Pregnancy and childbirth were high-risk ventures for most women during the colonial era, as rates of maternal and infant mortality were high. This was compounded for black women, who were often coerced into sexual liaisons and expected to produce babies. The extent to which slave owners participated in the deliberate breeding of slaves has been a topic of some debate; however, there is much evidence that the practice was common, especially after the importation of slaves was officially banned in the early 1800s. In his historical research using slave records, Stamppp found numerous references to the profitability of slave breeding and descriptions of women as "good breeders" (Stamppp, 1956). Research by Byrd and Clayton agrees. They write:

Slave women were encouraged, cajoled, and coerced by their owners to become pregnant. For not complying, some were whipped or sold. Some female slaves were purchased specifically for breeding. Women were often forced to engage in intercourse with strange men and males to whom they were not attracted. (Byrd and Clayton, 2000: 282)

Black children were potentially important sources of labor and capital for slave owners, and there was some concern over their high rates of death. Slave owners sometimes worried about high rates of miscarriage among their female slaves, fearing that they were deliberately aborting their pregnancies. But even those who managed full-term pregnancies had high rates of stillbirth, low birth weight infants, and infant mortality, likely due to the work patterns, nutrition, and the nursing practices of enslaved women. The high rate of infant death also resulted from lockjaw, due to poisonous breast milk from mothers. Some felt babies should be deprived of that milk, and came up with various ways to drain women's breasts, including the use of puppies (Long, 2012). Malnutrition was common among black children, and they seemed predisposed to diarrhea and respiratory illnesses. It was not uncommon

or diseases carried by fleas and insects (Byrd and Clayton, 2000).

The harsh punishment endured by black slaves created another source of sickness, injury, and death (Baptist, 2014). While laws forbade certain types of punishment for white indentured servants, such laws were not extended to enslaved Blacks. Whippings and food deprivation were common forms of punishment meted out to the poor and indentured servants but, as many have pointed out, mutilation, castration, nose-splitting, branding, crippling, and burning alive was almost exclusively reserved as punishments for those held in chattel slavery (Bankole, 1998; Byrd and Clayton, 2000; Baptist, 2014). A woman formerly enslaved in Louisiana, Mary Reynolds, said:

Slavery was the worst days that ever seed in the world.
They was things past tellin', but I got the scars on my old
body to show to this day. I seed worse than happened to
me. (Bankole, 1998: 5)

Although there was some debate over whether keeping slaves healthy or working them to death and replacing them was the most profitable, the former strategy seemed to prevail as slavery became more institutionalized and the importation of more slaves was prohibited. The prosperity of slave owners depended on the productive labor of slaves, even more so as the average price of a slave who worked in the field rose from \$200 in 1793 to \$1,000 in 1850 (Morais, 1968). While the growing value of slaves might have led to better treatment, the proliferation of slave revolts led to harsher penalties during the 1800s.

The extraordinary expansion of the nation's territory during the early through late 1800s made slavery even more vital to the economy; in fact, the policies of President Andrew Jackson included subjugating black people to permanent slavery and dispossessing Native Americans of their land to accommodate the expansion. The slave population grew from 1,771,656 in 1820 to 4,441,830 by the start of the Civil War, as enslaved Blacks were sent to western and southwest territories where they were subjected to the "most brutal and heavy work imaginable"—for example, land clearance, swamp drainage, tree removal, and preparing virgin land for crops like cotton, sugar cane, and rice (Byrd and Clayton, 2000). The expansion of slavery into these new areas had a devastating impact on black families, separating husbands from wives and parents from children, and contributed immensely to the black health deficit. With a more than doubling of the enslaved population, however, unrest over slavery was growing,

and it was abolished in a few states. Thus, the free black population began to gradually expand.

Medical care in early America

Families were the center of social and economic life in early America and the arena in which most medical care was dispensed. From the 1600s through the late 18th century, tending the sick took place in the domestic arena and was typically the responsibility of women. Little was known about the etiology of sickness, though it was widely believed that immorality and sin predisposed people to sickness and healing came through prayer, repentance, and medical interventions. For the latter, families kept on hand a stock of healing remedies passed on from earlier generations or gleaned from medical manuals. It was not uncommon for the home medicine chest to contain a wide array of medicines and medical devices—for example, calomel, castor oil, ipecac, jalap, opium camphor, and quinine were commonly stocked in homes, along with lancets, spatulas, and blister powders (Savitt, 1978).

Enslaved Blacks often drew on ancient African healing traditions such as herbs, roots, and conjuring. Although these strategies were often seen as primitive and of little medicinal value, Morais (1968) has argued that there were very few noticeable differences between the healing strategies of enslaved Africans and Whites. For both, treatment of illness occurred within the family, although the labor demands of slaves curtailed the time they were given to tend to the sick. For the most part, Blacks and Whites relied heavily on spiritual interpretations of illness and herbs, charms, plants, and minerals for healing. Black women were especially called on as midwives and for providing folk cures, and historians have found some instances in which enslaved Blacks were emancipated or given special privileges because of their healing abilities (Savitt, 1978, 2005; Byrd and Clayton, 2000).

Black women in the South, called “grannies” or “mormers,” often provided nursing care to the sick (Banks, 2011). Some Blacks with notable healing skills were called on to heal Whites, but they faced considerable risk when doing so. Slave owners lived in constant fear of being harmed or poisoned by slaves, and when the efforts of slaves to effect healing were unsuccessful or resulted in the death of the patient, even those slaves with good intentions could face dire consequences. Colonial states prohibited slaves from administering medicine to anyone—black or white—without the explicit approval of their masters, and passed laws authorizing the death penalty in

such cases. These laws, undoubtedly, made the practice of medicine a risky enterprise for enslaved black people, but did not end it. Between 1731 and 1812 black practitioners across the US, but especially in the South, created a slave health subsystem of various healers, including conjurers, root doctors, and others drawing on African traditions (Byrd and Clayton, 2000).

Slave owners were responsible for the health care of their slaves and authorized treatments at their own discretion. Claiming sickness could be risky for slaves, however, as it could result in punishment for malingering or being forced to accept whatever medical remedy they were offered (Long, 2012). One white physician in Georgia noted:

The negro is prone to dissemble and feign disease; probably no race of human beings feign themselves ill so frequently, and are so incapable of concealing their duplicity. (Savitt, 1978: 163)

Slave owners had to balance concern over malingering slaves with the cost of losing human chattel or having their diseases spread to their own families, and they drew on a variety of people to help manage sickness among slaves. Slave owners' wives or overseers were often given that responsibility, and some larger plantations set up slave hospitals. In severe cases of illness they called upon white doctors to treat their patients, as many claimed to have special knowledge about black diseases. Still, they could not ignore the healing abilities of many Blacks—enslaved and free—or the confidence that slaves often had in such healers. Slaves were often fearful of the medicines administered by their white owners, and in many cases were more responsive to the treatment of black healers. Slaves with known healing abilities, sometimes from nearby plantations, were often called on with favorable results (Owens, 1976).

As the population expanded with successive waves of European immigration and the steady importation of slaves, so did the array of healers and healing strategies that were practiced. In *The social transformation of American medicine*, Paul Starr noted that in pre-industrial America there were three dominant practitioners, all fairly equal in status: physicians, domestic healers, and lay healers (for example, bonesetters, midwives, botanists, etc) (Starr, 1982: 32). There was little agreement on either the cause or proper treatment of illness and the lack of a medical infrastructure made home care popular. Medical training was varied; nearly anyone who wanted to could practice medicine, and many did. By the late 1700s there were at least 4,000 medical

practitioners, about 400 of whom had medical training—which ranged from having studied in Europe at a prestigious medical school to having completed a relatively short apprenticeship in the US. The elite of the profession were “gentlemen” who refused to work with their hands, while those who learned medicine through an apprenticeship often used healing strategies as lethal as the disease, for example, bleeding, purging, and blistering.

Race and racism in medicine

As black slavery expanded and became more institutionalized, early theories of Africans as innately inferior to white Europeans also spread and influenced the practice and development of medicine, aiding in the exploitation of black people for economic gain. In medicine, black people were often compared with apes, and thus seen as non-human, unintelligent, and uncivilized. It was common to explain this with pseudo-scientific theories, such as the “great chain of being,” which argued that there was a progression from groups that were simple and animalistic to those who were advanced human beings. Blacks, of course, fell into the former group and were often subjected to tours that focused on their physical differences as proof of their less than human status. The case of Saartjie Baartman, a member of the Kung tribe of Bushmen of South Africa, is one of the best known examples. Saartjie was considered beautiful by her people, a group known as the Hottentots, but by Whites an example of one of the lowest forms of humanity (Byrd and Clayton, 2000).

Medical science eagerly embraced and advanced racist ideologies, which were uncritically accepted by most physicians. The consensus in the medical community was that black people were mentally and medically inferior to Whites, and that the “Negro race ... is a distinct species with separate origin from Caucasians” (Savitt, 1978: 8). Medical science documented the peculiarities of black people (for example, large breasts and penises, unbridled sexuality, strong body odors, strong tolerance for pain) and categorized certain diseases, such as chronic leprosy, locked jaw, and difficult parturition, as black diseases. Benjamin Rush, perhaps the most famous physician of the colonial era and an anti-slavery activist, advanced theories that contributed to scientific racism. Rush argued that the black skin, facial features, body odor, relative insensitivity to pain, and notorious sexuality of black people were due to a congenital, chronic form of leprosy.

framed in ways supportive of slavery and black inferiority. For example, studies pointed out that black people had lower rates of lunacy or mental illness—a fact attributed to their being simple and unthinking beings who had few worries because they were clothed and fed by others. Data collected for the 1840 federal census were used to claim that Blacks who were free were eleven times more likely than those who were enslaved to suffer from mental deficiencies, just one indicator of the perils of freedom for Blacks. William Weaver, a Southerner who was superintendent of the census, argued: “The African is incapable of self-care and sinks into lunacy under the burden of freedom. It is a mercy to give him guardianship and protection from mental death” (quoted in Morais, 1968: 32). Such knowledge prevailed, despite critics of the report who noted that some northern towns reported as having mentally ill Blacks actually had no black population at all. Biological determinism was central to the American worldview and embraced by scientific medicine; historians have noted that “this was not a fringe movement or the product of some group of ignorant, poorly educated extremists” (Byrd and Clayton, 2000: 248).

Despite this emphasis on racial differences in sicknesses which, presumably, would suggest the need for racially specific medical interventions, enslaved and freed African Americans—along with poor people in general—were widely used in medical experiments. Slave owners dosed their slaves with medical remedies to test their effectiveness, and Thomas Jefferson—a slave owner and founding father of the nation—tested vaccines using slaves (Downs, 2012). Slaves were especially used to demonstrate medical techniques and to test surgical procedures in an era when surgery was considered a death sentence. Medical schools and hospitals, in fact, boasted of having an abundance of “medical material” for their work (Savitt, 1978). Medical doctors and their students also disinterred bodies from pauper and black cemeteries, although the practice was illegal. J. Marion Sims, often called the father of gynecology, perfected his vaginal surgery techniques almost entirely on enslaved black women, often without anesthesia. In a few cases he conducted 20–30 surgeries on a single patient to correct the failures and mistakes of previous surgeries. Although some argued that Blacks were relatively insensitive to pain, in his clinical notes on one case of surgery on an enslaved black woman, Sims recorded: “Lucy’s agony was extreme. She was much prostrated and I thought she was going to die.... It took Lucy two or three months to recover entirely from the effects of the operation” (Bankole, 1998: 19).

Emancipation: a crisis of sickness and death

Historians and other scholars have documented the dramatic surge in disease, sickness, and death among the newly freed slaves that began during the Civil War and lasted through the early decades of the 20th century. Some estimate that as many as 25 percent of the black population died of sickness during the War and the early years of freedom (Smith, 1995). An in-depth analysis has been provided by Jim Downs' in *Sick from freedom: African-American illness and suffering during the Civil War and reconstruction*. Downs pointed out that contagious infections and diseases often caused more death during war than combat, and the Civil War was no exception. Overcrowding, unsanitary living conditions in army camps, insufficient resources, and the inability of medicine to control epidemics resulted in the death of thousands of soldiers from dysentery, pneumonia, smallpox, and measles. But those conditions took an even greater toll on the more than four million slaves who were liberated in a nation that was ill-equipped to handle their transition to freedom.

Thousands of slaves joined the Union Army, many motivated by the Militia Act of 1862. It declared that every enslaved man or boy who enlisted—if their masters were disloyal to the Union—would be freed, along with his mother and children (Long, 2012). Other slaves made the perilous journey to Union military camps seeking refuge, in some cases only to be sent back as violators of the Fugitive Slave Act. In other cases, they were declared “contraband of war,” confiscated as animals, and put to work performing manual labor. Living in military camps not only exposed them to diseases but confined them to makeshift communities where the living conditions were abysmal and food shortages and starvation common. Their initial dislocation was often compounded by being moved from camp to camp, with little concern for those who were sick or emaciated.

The War devastated the agricultural economy of the South, leading to high rates of poverty, famine, and poor health. Southern states could scarcely provide health care and other assistance for their white citizens and, as Beardsley has argued, they had practically no incentive to provide help to African Americans (Beardsley, 1990). Debate raged among politicians over whether the states or the federal government should assume responsibility for providing medical care for former slaves. The federal government finally responded by establishing a Medical Division of the Freedmen's Bureau, which built hospitals and almshouses and staffed them with hundreds of health care workers. Such facilities, however, fell far short of providing health care to the

newly freed slaves, whose poor health was explained as indicative of their inferiority. The collection of data by the federal government supported theories of innate black health inferiority, as it found that by the late 19th century Blacks had higher rates of sickness than Whites and shorter life spans. At this time, the life span for Whites was 50 compared to 30–32 for black men and 34 for black women (Byrd and Clayton, 2000), further evidence of greater black vulnerability to poor health and early death. Moreover, the mission of the Medical Division was to create a healthy labor force, and concern that providing health care services to black people would foster dependency led to limited funding and resources (Downs, 2012).

The health and mortality crisis resulting from emancipation and the absence of adequate policies to aid formerly enslaved Blacks in adapting to freedom continued throughout the early decades of the 20th century. The problem was exacerbated as African Americans left rural areas and plantations and made their way into southern urban areas. As Long has explained:

The newly arrived African Americans faced an immediate housing and employment shortage. The inadequate housing procured by many was crowded, ill ventilated, and bereft of a sanitary water supply or functioning sewage system. These problems, combined with poverty and unemployment, made for the ideal conditions for the spread of epidemic diseases such as smallpox, cholera, and yellow fever. (Long, 2012: 102)

Some southern states that once had provided a modicum of health care for the poor now insisted that those services were for citizens only, which excluded African Americans. Smallpox, cholera, and yellow fever took a devastating toll on Blacks, most of whom did not receive (and sometimes simply refused) the vaccines that were available. Black fertility rates declined sharply between 1867 and 1935, attributed mainly to sexually transmitted diseases, poor diets, and unsanitary living and birthing conditions (Beardsley, 1990). Poor health and high rates of death among African Americans reinforced the “theory of racial degeneracy”—a belief widely held by politicians, doctors, and the public that slavery had a civilizing impact on black people, but with freedom they were reverting to their native savagery (Summers, 2014). Some public health doctors argued that improved environmental conditions would help, but most held that Blacks suffered due to their

“inherent shiftlessness, low intelligence, and love of carnal pleasure” (Beardsley, 1990: 124).

Articles in the *Journal of the American Medical Association* in the early decades of the 20th century examining the health plight of “the negro” emphasized that the abolition of slavery had resulted in high rates of insanity, consumption, syphilis, and immorality among black people. In a 1900 address before the Tri-State Medical Society of Virginia and the Carolinas, Dr Barringer argued that Blacks were reverting to savagery so rapidly that “unless a brake is placed on ontogeny of this savage, the South will be uninhabitable for whites.” A revisionist perspective on the harsh realities of slavery cast it as a paternalistic system in which Blacks were well-cared for. An article by Dr Murrell argued that as a “valuable form of energy,” enslaved Blacks received the best of housing, nutrition, and clothing in order to maximize their labor potential, and then—overlooking the impact of the absence of those basic resources necessary for survival—he explained that with abolition “morality [became] a joke among these people.” According to another doctor:

Freedom removed all hygienic restraints and they [Blacks] were no longer obedient to the inexorable laws of health, plunging into all sorts of excesses and vices, and having apparently little control over their appetites and passions. (Powell, 1896: 1186)

Others linked the lack of mortality to the development of the brain. A short article in the *Journal of the American Medical Association* noted:

The lower mental faculties of the negro, such as smell, sight, handicraftmanship, body-sense and melody, are well developed, but in the higher faculties, self-control, will power, ethical and aesthetic senses, and reason, the negro falls considerably behind the Caucasian. (*Journal of the American Medical Association*, 1906)

Many believed Blacks were on the verge of racial extinction, and there were few efforts to reverse that trend. The presumed biological inferiority of black people was used as evidence of the ill-effects of miscegenation. In the mid-1800s the federal census counted the number of mulattoes in the slave population with the goal of examining the mental and health consequences of being interracial. Census data revealed white ancestry was common among slaves—about 20 percent of slaves in some states were mulattoes and 30 percent of free Blacks

were mulattoes, leaving one historian to muse that slavery was getting “whiter and whiter” (Humphreys, 2008). Miscegenation became the focus of the medical community. In 1907, the Tennessee State Medical Association offered a medical report that pointed out:

It is principally the yellow Negro that shows the enormous death-rate from tuberculosis today. In all cases, wherever we find a hybrid race, we find a race which has not the stamina, physical, moral or mental, of either of the races in the mixture. (quoted in Smith, 1999: 22)

Throughout the first half of the 20th century, doctors and medical scientists continued to argue that black people had an inherited immunity to certain diseases, such as malaria, influenza, and the mumps, and a propensity towards others, such as tuberculosis (Oppenheimer, 2001). Most embraced the “black pest thesis,” referring to black people as vectors for diseases that could infect white people. These medical theories resonated with the 1896 US Supreme Court decision legalizing racial segregation and provided the foundation for the segregated medical system.

The rise of the dual health care system

The modernization of the American health care system emerged amid emancipation and a rapidly industrializing economy. By modernization is meant the rise of scientific medicine and of professional dominance by allopathic physicians, their power garnered largely from advances in medical knowledge and political lobbying.

As late as 1850, allopathic or “regular physicians” struggled for control over the health care system but remained “weak, divided, insecure in its status and its income, [and] unable to control entry into practice or raise the standard of medical education” (Starr, 1982: 7-8). But the final decades of that century proved transformative for them as the germ theory of sickness became the basis for scientific medicine. The rise of scientific medicine and the power and authority of physicians resonated with the turn of the century emphasis of modernization, professionalization, and science. Membership in the American Medical Association (AMA), which was founded in 1846, soared in the last decades of the century, as it became the best-funded and most powerful lobby in US. Through these efforts, physicians

lobbied for and received a virtual monopoly on the right to practice medicine (Freidson, 1970).

The modernization of medical care and the rise of scientific medicine led to a vast expansion of the health care industry and a standardization and improvement in medical care. Providing medical care was no longer the responsibility of the family but was transferred to doctors and hospitals. In 1873 there were fewer than 200 hospitals in the US, but by 1920 there were more than 6,000 (Starr, 1982). The separate but equal doctrine established in 1896 led to the creation of a dual health care system based on race. Southern states constructed their entire hospital system on the doctrine of racial separation, and African-American patients in the North also often received care in racially segregated facilities (Quadagno, 2000). The years between 1832 through 1965 marked the height of segregation in the field of medicine. Black patients usually found themselves in segregated waiting rooms in doctors' offices and medical facilities, where they often had to wait until white patients were served before receiving treatment. As one African-American female recalled:

I remember when I was a teen I had to help my grandmom go for care at Greenville General. She had cancer. We had to wait in a horrible small room for black patients in the basement. We'd get there by 9:00, and we often didn't return until 5:30. The local mortician provided the transportation to the hospital. The understanding was that the transportation was free, but he would get the body. It wasn't a bad experience. It was the way it was. (quoted in Smith, 1999: 10)

Access to hospital care was scarce for black patients during the early 20th century. Most hospitals did not accept African Americans, and those that did usually relegated them to segregated wards that were dilapidated and overcrowded. Of the 127 Veteran Administration hospitals that existed in 1947, 24 of them had separate wards for black patients and another 19 admitted Blacks only for emergency treatments (Shea and Fullilove, 1985). In 1930, only 225 of the nation's 7,259 hospital beds were reserved for black patients (Morais, 1968). Black patients sometimes died after being taken to a hospital where all the "black beds" were taken, even if some "white beds" were still empty. African-American doctors and their supporters, however, managed to establish at least one black hospital in nearly every southern state. The most famous was the Tuskegee Institute Hospital and Nurses Training

School founded in Alabama in 1892, which, after the First World War, became the center of care for over 300,000 black veterans in the South (Watson, 1999). Still, having the hospital staffed by black health care professionals was the result of a prolonged battle between white supremacists and black physicians and their supporters.

African-American health care workers

African Americans interested in providing medical care also found themselves relegated to the margins of medicine. Although those who had traditionally practiced spiritual and folk healing were now stigmatized as superstitious or quacks, there were limited opportunities for Blacks who wanted to study scientific medicine to attend medical schools. Some African Americans had managed to obtain formal medical training in the 1800s, and by 1890 there were 909 black male doctors (Hine and Thompson, 1998). Between 1848 and 1860, the closing decades of slavery, five medical schools admitted black students: Bowdoin, Harvard, Dartmouth, Western Homeopathic College, and the New England Female Medical College (Watson, 1999). After the abolition of slavery, several black medical schools were established, including Howard University Medical School and Meharry Medical College. Many white people were amused at the notion that African Americans could become physicians, as the two statuses seemed so incongruous. Long (2012) noted that caricatures of black doctors were common in the media, such as an 1899 publication titled *The medicine man – A coon song*.

Although women were being driven from the field of medicine, a few managed to get formal medical training. In 1864 Rebecca Lee graduated from the New England Female Medical College in Boston and became the first black woman to earn a medical degree. Most black women who completed medical school held little hope of practicing in the US and acquired medical training in order to become missionaries and use their training to work in poor nations, especially Africa (Watson, 1999). Black women, especially in southern states, continued to be heavily involved in midwifery, which they considered an extremely prestigious occupation. In the early 1920s southern states hired public health nurses to oversee midwives, to make sure they were registered, wore proper clothing, and met other health-related requirements. But white physicians increasingly criticized the role of women in delivering babies. In 1925, a prominent physician described the black midwife as “filthy and ignorant and not far removed from

the jungles of Africa, laden with its atmosphere of weird superstitions and voodooism" (Smith, 1995: 125).

In the early decades of the 20th century African-American medical students continued to face formidable barriers in acquiring a medical education and practicing medicine. One problem was that most of the black medical schools founded in the post-slavery era were closed by the early 20th century, as they were unable to meet the educational standards set forth in the Flexner Report on medical education. The Flexner Report reinforced the racial divide in medicine and the marginalization and shortage of African-American doctors. The section of the report entitled "The medical education of the negro" endorsed training of some black doctors, "if the negro can be brought to feel a sharp responsibility for the physical integrity of his people." It argued that black doctors should be trained mostly in preventive medicine, rather than fields like surgery, and should be trained to "humbly" serve black people as "sanitarians" (Long, 2012: 58). Flexner focused on the public health function of black doctors, noting that Whites needed a barrier from the diseases and infections that were common among African Americans (Summers, 2014).

Few African Americans were able to enter medical schools. Between 1920 and 1964, only 2-3 percent of students entering medical schools (mostly Howard or Meharry) were Blacks. Once they completed medical school black doctors found it difficult to obtain the residencies or internships they needed to complete their training. In 1927, for example, only 21 of the 1,696 hospitals in the nation employed black interns, and of them, 14 treated only black patients (Blount, 1984). Most black doctors were unable to train in the most prestigious medical specialties and were concentrated in fields such as family medicine and pediatrics. Sonnie Wellington Hereford, who was trained at Meharry in the 1950s and practiced medicine in Alabama, described the segregated hospital this way:

The Colored Wing had one large room that served as our emergency room, delivery room, and operating room—what we called the ER, DR, and OR. The hallways could accommodate another ten or twelve beds; the administration did not mind having people lying out in the hall so long as nobody tried to go over to the other side. (Hereford, 2011: 58)

Racial codes governed everything from minor issues (for example, clerks refused to put "Mr" or "Mrs" on black patients' records) to

access to facilities and behavior. Dr Hereford pointed out: "We were not permitted to eat at staff meetings. We were not permitted to dictate our records on the hospital Dictaphone. We were not permitted to administer anesthesia. We had to watch ourselves every step of the way ... to be a perfect gentleman every minute."

Another factor restricting the professional development of black doctors was their inability to join the AMA. Although it claimed to have no racial restrictions on admission—and it did have some black members—only doctors who were members of the local medical society could join. But many of these local medical societies, especially those in the South, did not admit African-American doctors. This marginalized black doctors, since membership was linked to hospital privileges, access to state licensing bodies, forming supportive networks, and participation at conferences where new research was presented (Baker et al, 2008).

African-American physicians fought for membership in the AMA but also formed their own state and local medical societies, perhaps most notably in 1895 establishing the National Medical Association. They also founded the *Journal of the National Medical Association* and published numerous articles that challenged the claims by white physicians and scientists that poor health among African Americans was the result of biological inferiority. They led the charge in attributing the poor health of African Americans to racism and segregation, while also encouraging Blacks to improve their hygiene and living quarters and to embrace modern medicine (Summers, 2014). The National Association of Colored Women, formed in 1896 and headed by middle-class black women, was especially active in health care. They saw racial uplift as their mission, especially helping African Americans conform to mainstream social and cultural values in order to challenge racial stereotypes. They were joined by a host of other black professionals, such as social workers, midwives, club women, and educators. By 1915 a National Negro Health Week had been established.

Although the field of nursing began to flourish with the rise of hospitals and was defined as a female occupation, African-American women found it difficult to get training and employment in the field. No nursing school in the South accepted black applicants and only a few in the North did. Due to the activism of black doctors and other community leaders, Provident Hospital in Chicago was established for black students in 1891, and others followed. In 1899 the New England Hospital for Women and Children in Boston graduated six black nurses, including the first black graduate nurse in the country, Mary Eliza Mahoney (Morais, 1968). Nurses in general and black

nurses in particular faced major obstacles to finding jobs after they graduated from nursing school. The hospitals that had exploited their labor as trainees had little incentive to hire them once they completed their training. Mary Carnegie, a black nurse who graduated in 1937, recalled that only about four of the 200 hospitals in the metropolitan New York City employed black nurses, and two of them assigned black nurses only to care for black patients in the tuberculosis wards (Carnegie, 1985).

Challenging segregated medicine

Although a segregated medical care system lasted until the 1960s—nearly 100 years after the abolition of slavery—African-American doctors, communities, and activist organizations worked to both challenge segregation and develop health facilities to address the immediate health care needs of the black population. With substantial funding from several foundations (for example, Rockefeller, Rosenwald, Duke Endowment), black physicians managed to establish health care facilities for black people in most communities, especially in southern and rural areas (Beardsley, 1990). Despite these efforts, the black health deficit seemed to grow in the early decades of the 20th century, much of it related to the massive northward migration of African Americans. Northward migration disrupted families and undermined health, even more so when migrants failed to find jobs and better living conditions.

The Great Depression of the 1930s led to a severe reduction of health care resources, and most African Americans who migrated North experienced a decline in health. For example, by 1940, death rates for Blacks were 33 percent higher than for Whites. Life expectancy for white males and females had risen to 62.1 and 66.6 years, compared to 51.5 for black men and 54.9 for black women. Prior to the Second World War, numerous black deaths were attributed simply to “ill-defined conditions,” and as late as 1940, black deaths from “unknown causes” were ahead of cancer as a leading cause of death among African Americans (Beardsley, 1990). The economic decline facing the nation led the federal government to pass New Deal policies and the Social Security Act to spur job development and provide welfare benefits to the elderly and poor. Although some black people benefited from these policies, racial politics ensured that they did so minimally. Many Blacks were ineligible for old age assistance because they worked in farming or as domestic servants, and those who were eligible often

received lower benefits based on the fact that they had a lower standard of living (Quadagno, 2000).

The entry of the US into the Second World War sparked a surge in manufacturing jobs, ended the Great Depression, and brought new opportunities for black physicians and nurses. About 1.2 million African Americans served in the War, which led the federal government to increase the number of black medical personnel. By the end of the war, about 600 black doctors and 500 black nurses had been incorporated into the armed forces. The economic standing of most Americans, including African Americans, improved after the Second World War due to a thriving industrial economy. Still, by 1949 the median black household income was still only 51 percent of that for white households (Morais, 1968).

The Second World War and the post-war economic affluence produced more opportunities for black doctors and nurses, but did not eliminate the segregated medical system. However, the National Association for the Advancement of Colored People (NAACP) won some impressive victories in the 1940s and the 1950s that opened more medical schools to African Americans. It successfully sued the University of Arkansas for refusing to admit black medical students, forcing it to integrate, and a few other states followed (Shea and Fullilove, 1985). During the 1940s, support for a national health care system that included the black population found a powerful advocate in Oscar R. Ewing, head of the Federal Security Agency. In 1940, only 9 percent of black people had hospital insurance, compared to 50 percent of white people, and the health profile of African Americans was a major factor in the nation's mortality and morbidity statistics (Thomas, 2011). Arguing that the facts of Negro health "reveal a picture of needs, misery, and desperation almost beyond belief," Ewing said:

We have no right to be complacent about that. The life of the poorest Negro is just as important to him as yours is to you, or mine to me. His death means as much grief and sorrow to his family as your or my death would mean to our loved ones. (quoted in Thomas, 2011: 252-3)

Nevertheless, the federal government had begun to invest huge sums of money into health care, especially the construction of hospitals, but without challenging racial segregation. In 1946 the Hospital Survey and Construction Law (or the Hill-Burton Act) established hospitals and health clinics for the underserved, but it included a "separate but equal" clause that led to the creation of separate hospitals and facilities

for black people. By 1974 the Hill-Burton program had distributed more than \$3.7 billion to states and generated an additional \$9.1 billion in local and state matching funds (Quadagno, 2000). The South received a significant share of those funds, which enabled states to actually strengthen their racially segregated facilities. The NAACP filed numerous lawsuits challenging the use of federal and state funds for racially segregated facilities, but were unsuccessful as hospitals were classified as private entities (Quadagno, 2000).

By the mid-1950s, protest against racial segregation became the focus of an organized civil rights movement that led to the Civil Rights Act in 1964. Since that time, more attention has been devoted to racial inequalities in health and the health care system. One significant study of the era, published by Harvard University Health Services in 1966, reported that serious mental and physical diseases were so common among African Americans that they seemed normal, including rat bites, rotted teeth, parasitic diseases, and developmental disorders (Morais, 1968: 154). Significant efforts were initiated to create a racially integrated medical system, including a 1965 amendment to the Hill-Burton Act ending federal funding for racially segregated hospitals. Many southern hospitals resisted the policy and developed new strategies for maintaining racially segregated facilities. However, the incentive to integrate grew when the federal government passed Medicaid and Medicare, providing millions of dollars to cover the medical expenses of the poor and elderly, but prohibiting the distribution of those funds to segregated health care facilities (Quadagno, 2000).

In 1966 all US medical schools opened to African-American students, some instituting policies of affirmative action to recruit racial minorities, and in 1968 the AMA accepted African Americans as members. Between 1971 and 1976 the Robert Wood Johnson Foundation provided \$10 million to medical schools as scholarships for minorities, women, and rural medical students (Shea and Fullilove, 1985). Some of these initiatives, however, have waned in recent years, due to challenges to affirmative action policies and less funding for medical schools. Occupational segregation has also continued to be a problem, with slightly more than half of the nearly 28,000 black physicians in the US concentrated in the lower paying and less prestigious medical fields—family medicine, obstetrics-gynecology, internal medicine, and pediatrics. The income gap between black and white physicians was constant between the 1960s and the 2000s, with African-American physicians earning about 70 to 77 percent as much as white physicians, largely explained by specialty field and the racial composition of patients (Kornrich, 2009).

Conclusion

The health deficit experienced by African Americans dates at least back to slavery, which defined black people as chattel and propagated numerous theories that explained their poor health in terms of racial inferiority. This theme was given scientific merit during the early formation of the medical system and especially in the decades following the abolition of slavery. Although there has been significant progress in challenging these racial theories and dismantling the segregated medical system, the black-white racial disparity has persisted. The following part of this book looks at how it is perpetuated by health behaviors, social settings, and health policies.