CHAPTER XVI

SPECIAL PROBLEMS IN THE PROVISION OF MEDICAL SERVICES FOR NEGROES

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THE PRESENT SCENE

On the present scene we are witnessing a gradual awakening as to the nature and significance of health problems in our national life, and to especial consciousness of the situation of the Negro in respect to them. Superimposed upon the well documented difficulties of shortages, poverty and ignorance, is a maze of conflicting interests and confused thought on the part of both the majority and minority populations. This in itself constitutes a special set of problems in the development of adequate medical services for all. Neither group as a whole has yet a clear prospective upon the facts and their import, and both harbor surprising delusions both as to the situation and the possibilities of specific types of remedy.

Recent especially directed efforts on many fronts, described elsewhere,[1,2] have been definitely effective in arousing public interest and the national conscience. The types of response range from the position of this writer, nationwide organizations like the N.A.A.C.P. and others, that equal justice in medical care cannot be achieved under a segregative system and that it is just as well to realize this now as later and set our sights accordingly, to that of a leading white surgeon in the capital of a Southern state who told the Negro president of a Negro college in his state, "You know Dr. ————, I've been thinking a lot about your health problem lately, and I really think n————s ought to have *something*."

Despite this wide range in viewpoints, thought is churning on these issues where it has never churned before. Recent events have indicated so positive a trend in progressive directions that it would seem necessary only to keep active attention concentrated on the problem to assure the development of lasting solutions wholly in keeping with the American Constitution and professed way of life.

If the kinds of problems discussed in this article seem in any sense discouraging, it is to be remembered that within the past year, a Southern medical school has admitted a Negro student, a Southern county medical society has voted to admit Negro physicians, a Southern state medical association has altered its constitution so as to permit the admission of Negro doctors to local societies, and the American Nurses Association has amended its constitution so as to permit qualified Negro nurses to join, who are barred from their local associations solely because of race.

[1] W. M. Cobb, Medical Care and the Plight of the Negro. New York: N.A.A.C.P., 20 W. 40th Street, N. Y., 1947, pp. 38.

[2] ....., Progress and Portents for the Negro in Medicine. New York: N.A.A.C.P., 20 W. 40th Street, N. Y., 1948, pp. 53.

Philosophic Divergence

Almost everywhere the idea of abandonment of segregative policy in the working out of remedial measures encounters strong resistance. This may come from Negroes as well as whites.

The white sources, of great power and influence, whose avowed purpose is to thwart at any cost any change in the *status quo*, are only too well known. Then there are thousands of outstanding white citizens of goodwill who sincerely believe, according to their lights, that the present is not the time for radical changes — a step, maybe several in the right direction, perhaps, but things will work themselves out gradually if folk don't try to rush them too much. These apostles of gradualism would bequeath to posterity the problems they are unwilling to face frankly, much less solve. Finally, there is a smaller number of white Americans of unquestionable prestige, integrity and loyalty, who freely acknowledge that segregation is wrong and that efforts to equalize health provisions among other things, within its framework are doomed to futility. This heresy tends to render them suspect of everything from mental inadequacy to allegiance to foreign political ideology.

The complacency of Negroes toward the established order is as puzzling as it is widespread. Despite the signal achievements of militant organizations like the N.A.A.C.P., of community progress through groups like the National Urban League, and the constant protest-needling of the Negro press, there is an astonishing amount of inertia among Negroes themselves at all levels, even in highly literate areas where everyone would be expected to know better.

Among Negro leaders of declared opinion, may be discerned a variety of positions which overlap in part those of the majority groups, although of different motivation. The National Medical Committee of the N.A.A.C.P. has given clearest enunciation of the necessity of total abolition of segregation and discrimination in health matters. Other leadership openly or tacitly holds that less important than the principle of approach is the matter of getting what you can, when you can and as you can. There are even some who hold that segregative arrangements preserve the peace, that progress is being made under them and that the proponents of fundamental change only "set things back."

Factual Ignorance

Surprising as it may seem, an astounding segment of the presumably well-informed public is actually ignorant of the deficits in existing provisions for health care, as well as in the future outlook. One meets respected and influential citizens "who just didn't realize how things are." They would know of the Howard and Meharry medical schools of course, and had thought that these were training enough health personnel for the needs. It is a shock to these good people to learn that even an expanded Howard or Meharry could not begin to meet the needs, nor could expansion of the total Negro medical diaspora contain the problem.

Exploitation of Segregation

Segregation is naturally not opposed by those who exploit it, even though lip service may be given to plans for its elimination. Both white and Negro physicians may be found who profit from segregative arrangements. The longer they have been established in their practices the less adjustable they become and the more they feel their security menaced by movements for change. To many white physicians, particularly ambitious younger men, the Negro patient represents clinical experience. Such physicians have no love for the Negro, but they want to control the clinical material he represents so they try to keep control of the Negro wards, even of the most abominable character, in segregated hospitals, and also of voluntary or semi-private Negro hospitals. They thus get opportunity for all the surgery, with contract fees in many places, and are able to practice at a level at which they could not compete with a strictly white practice. These men do not welcome the advent of well-trained Negro physicians and use the stone wall of local custom as a "stall" to deny them hosptial staff privileges.

On the other hand, Negro physicians may be found who are as a result of finding themselves barred from hospital and other opportunities for care of their patients and for professional improvement, establish second-, third- and fourth-rate private institutions in which service must be cut to the bone to realize a profit. None would defend these institutions as adequately compensatory, but it is claimed that they are better than nothing. The prospect of opened doors and new public facilities represents a threat to the inflated livelihood of this group. Consequently they subversively oppose change. Realistically, they see themselves at a disadvantage in improved set-ups, because the responsible authorities in various places generally think only in terms of younger newly-trained men for new openings.

Atavistic Views

Obsolescent points of view survive in unexpected places. It is universally recognized today that disease is color-blind and that the way to eliminate a disease is to treat its victims and strike at its causes wherever they exist. Yet we may find trained public health officials whose utterances and official acts indicate a concept of disease as a racial problem.

The Health Officer of the District of Columbia, for example, has over a period of years represented tuberculosis as a Negro problem in Washington and recently went so far as to suggest that Negroes who proposed to come to the Nation's Capital to live should be screened for visible means of support and housing.

Local Repellents

The home missionary attitude has been strongly inculcated into the Negro physician in training. He has been urged, as a duty, to go South where he is so sorely needed. But there are indications that the South will need to become more civilized before it can hope to attract its necessary health personnel.

Recently in a deep Southern state a young urologist, the only specialist

in that field in the entire South, who had gone to practice there with the objective of rendering service where most needed, was driving on a state road with his wife and two children.. State policemen overtook him and accused him erroneously of a minor violation of law. His protests were of no avail. He was yanked from his car, his wife's pocketbook searched ostensibly for a concealed weapon, really to see how much money she had. The doctor was considerably "roughed up" not actually beaten, fined the approximate sum he and his wife had on their persons and sent off in an insulting manner. There were local community protests without effect. This specialist is now practicing in a Northern state and a potential successor will think twice before establishing in the same parts.

Indirect Pressures

There will often be no Negro representation on public boards of health of various categories, and certainly none on non-Negro voluntary hospital boards. Even where there is Negro representation on public boards attempts are frequently made to secure persons who are not of the militant type and will cause no "trouble." This decreases or nullifies the effectiveness of the representation.

On the boards of Negro hospitals there are generally a few white members. Even here, however, the Negroes may fail to act with an expected progressiveness and independence because of indirect controls which the white community can exercise over individual influential members.

Legal Compulsion v. Private Volition

There is often a paradoxical situation in which communities readily do under legal or political pressure what they seem totally unable to bring themselves to do of their own volition. Thus cities can be indicated in which Negroes, after gaining political power, secured appointment of physicians to municipal hospital staffs and where after nearly two decades experience with Negro physicians in such positions only the most wholesome relationships have developed. Yet in the same places none of the boards controlling the voluntary hospitals of the locality has taken similar steps in the institutions under their control, despite the strongest representations.

Here and there very constructive beginnings have been made in bi-racial collaboration on problems which must be dealt with through local boards. The most significant large scale effort in this direction was the Community Relations Project of the National Urban League which through surveys during 1945-47 of thirteen major cities, contacted and interested local community boards to an extent never reached before.

Another example of the results of such effort is the report of a bi-racial conference on health problems sponsored by the American Friends Service Committee in March, 1949.

> It was the general concensus that such efforts should be directed along two separate lines — viz., primarily, that 'majority group members' should bring these problems to their hospital boards, school boards, etc., for the purpose of stimulating direct remedial action so that equal opportunities may exist for

all persons, and secondly, an all-out campaign to educate the general public.[3]

Impasses

Attempts to effect improvements through new measures, public or voluntary, often are greatly delayed or come to a standstill over the manner in which a law or will or organizational action is to be implemented.

In one case a will bequeathed a huge sum for construction of a hospital to be open to all. The white executors being unwilling to do this have used various methods to try to induce the local Negroes to accept an addition to their own separate hospital as being "best for them." Legal difficulties and the reluctance of Negroes to accept a forced compromise have forced matters to drag on several years. Meanwhile nobody has the hospital.

Attempts to get saber-toothed anti-discrimination measures written into Federal law have been unsuccessful. Thus, the Hospital Survey and Construction Act, Public Law 725 of the 79th Congress, only provides for equal facilities in such localities as have separate facilities as local custom. Consequently, the problems of duplicate facilities have delayed hospital construction plans in some places.

Financial Burdens

Negro hospitals generally have great financial difficulties. Too often before advantage can be taken of new public or private funds which may be available, an old debt must be cleared up. This requires a community campaign of depressing effect, because of the realization that the effort must go not for something new but to liquidate an accumulated obligation.

Integration Misoneism

Simple fear of the new affects both Negroes and whites who address the problem of expanded opportunities for health care on an unsegregated basis. This is particularly detrimental to the cause of the Negro.

Too many cases have occurred in which after much effort new openings for places in medical schools, for interneships or for hospital staff positions have been created, but the potential candidates for them did not present themselves to follow through to the great embarrassment of all who had labored for the openings. This failure of the Negro to realize that these transitional times call for pioneer spirits, and the failure to produce them in quantity, is a serious indictment which should not be taken lightly by educators and community leaders all over the country.

Organizational Representation

Negroes have never had positions or representation of strategic importance in the great organizations which determine health policies and practices in this country. This includes the American Medical Association, the Association of American Medical Colleges, the United States Public Health Service and the Veterans Administration. Some major private health organizations have lately added Negroes to their directorates. In this group are the National Tuberculosis Association, the National Society for Crip-

[3]Philadelphia Fellowship Commission, Report to the Community. May, 1949, p. 3.

pled Children and the American Cancer Society.

Negro organizations have not compensated for the lack of significant or key position in the major national bodies, nor can they. There is evidence, however, that groups like the National Medical Association and the National Dental Association are seeing their responsibilities as a professional force more clearly and that they may so act as to exert more influence in the future than in the past.

Confusion on Controversial Issues

Negro health personnel and the public naturally seek to determine how much the Negro would benefit from legislative proposals to improve the availability of health facilities and medical care. In respect to the omnibus health bill now before the Congress which has been specifically designed to carry health care to the places and people who need it most, it has been surprising to see schisms arising among Negro professionals. The dissenters contend that in the South the Negro will not get any more under the proposed bill than he does now. Though such a viewpoint is seemingly unbelievable, it reveals simultaneously the depth of distrust of the South on the part of some Negro doctors, a certain gullibility to propaganda hostile to national health insurance and fear of threat to income. In this dilemma numerous Negro doctors are timorous about asserting independence of the American Medical Association, despite that body's historic indifference to their welfare.

Conclusion

The enumeration above is not comprehensive but merely suggestive of the number and complexity of the special problems addressed in the matter of improving provisions for the health care of Negroes. The considerations mentioned, however, should be enough to point-up the fact that health is not a racial matter. We shall be on the road to better health for all when our 79 medical, 41 dental, 65 pharmaceutical and 1313 nursing schools, as a collective national resource for the training of health personnel, are open to all qualified citizenry, when all citizens have equal opportunity to prepare for such training, and when the means to receive and pay for adequate medical care are available to all.

A broad educational program to convey to all citizens the essential facts about the maintenance of health in our social order is indicated to clarify the maze of misconceptions, misapprehensions, misoneisms and mistrust which is likely to becloud the minds of any average group of citizens today which sits down around a table to plan improvements in health conditions in neglected areas. What the country needs is a thorough introduction to the basic facts of anthropology. Corrective legislation is a vital essential, but we must work increasingly hard at sitting down around a table to work out solutions to our problems with honesty, sincerity and just purpose.

Chapter XVII

THE SUPPLY OF NEGRO HEALTH PERSONNEL—PHYSICIANS

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Medical Education and the Shortage of Physicians[1]

A shortage of both Negro and white physicians is accepted as a fact by the organized medical profession, medical educators and government officials. Such disagreement as may exist is in the extent of the shortage and the steps which may be considered most desirable for relieving the shortage. It is also generally agreed that the shortage is more acute in the number of Negro physicians. Again there are differences in opinions as to why the shortage is more acute as to Negro physicians and how relief may best be effected. There is rather widespread agreement that racial discrimination against Negroes in medical education and in professional considerations is a factor of much importance.

Examination of the facts relative to the number of Negro physicians and the number of Negro medical students may be significant. In thirteen definitely Southern states the Negro population is 9,752,326; there are in those states nineteen approved four-year medical schools and two approved two-year basic science schools.

[1]*Medical Schools of the United States in 1949*

	Private	State	Municipal	Total
Four Year Medical College	43	25	3	71
Two Year Basic Medical Science Schools	1	6	0	7
	44	31	3	78

Annual admissions to medical schools in (Table II). Of these twenty-one schools nineteen, to date, have an exclusion policy toward Negroes.

The University of Arkansas School of Medicine admitted one Negro in 1948, the first in the school's history. Meharry Medical College in Nashville, Tennessee, organized in 1876 by private philanthropy for the education of Negro youth, is the only other medical school in these thirteen Southern states where a Negro may enroll. Of these twenty-one medical schools in thirteen states with nearly ten million Negroes, twelve are state or municipal schools and nine are private schools. In twenty of the twenty-one medical schools in these thirteen Southern states (Meharry Medical College excluded) there were 5,299 students enrolled and of that number there was only one Negro, that one being one of 274 students enrolled at the University of Arkansas School of Medicine. If the 234 students enrolled at Meharry Medical College are added, the total enrollment of medical students in these thirteen Southern states for the year 1947-48 is 5,533 of which number 235 are Negroes. In that same year the four-year approved medical schools in these thirteen Southern states, exclusive of Meharry Medical College, graduated 1,180 students as Doctors of Medicine, but there was not a Negro among the number. From those thirteen states with a Negro

TABLE I

POPULATION-PHYSICIAN RATIOS, MEDICAL GRADUATES, NEGRO POPULATION FOR NORTH, SOUTH AND WEST

States[a]	Number		Per cent		Total Persons Per Physician[b]		Negro Persons Per Negro Physician[c]		Total Medical Graduates 1947-48	Negro Medical Graduates 1947-48
	1940	1948	1940	1948	1940	1948	1942	1948		
	12,865,518	13,818,504	9.8%	9.45%	751	[illegible]	3,376	3,681	[illegible]487	137
	9,261,792	9,752,326	25	24.8	1,060	[illegible]	5,832	6,203	1,238	58
Area and District of Columbia	642,827	768,629	13.8	14.6	628	691	1,494	1,808	374	64
gland	101,509	113,485	.79	1.22	619	658	1,845	1,668	333	2
Atlantic	1,268,366	1,366,690	9.86	4.58	592	520	1,997	2,564	1,363	4
orth Central	1,069,326	1,208,741	8.31	4.04	749	867	1,516	1,709	1,137	7
orth Central	350,992	372,187	2.73	2.66	812	850	1,150	1,265	619	0
in	36,411	42,688	.28	.94	834	734	2,022	3,283	88	0
	134,295	193,758	1.04	1.36	625	[illegible]	1,814	1,374	335	2
al	12,865,518	13,818,504	9.8%	9.45%	751	[illegible]	3,376	3,681	5,487	137

opulation United States:
0—131,669,275
8—146,114,000

[c]Total Number Negro Physicians:
1940—175,163
1948—193,432
1942—3,[illegible]
1948—3,[illegible]

tors of Medicine. Meharry graduated fifty-eight in 1947-48. Therefore, of 1,238 students graduated from the medical schools of the South only 58 were Negroes, (Table II). Approximately 4.5 per cent of the graduates in medicine in that area were Negroes, although about 25 per cent of the total population is Negro. All things else being equal and no racial discrimination existing, we might have expected 317 of the 1,268 doctors to be Negroes instead of only 58.

In the border area of Maryland, Delaware, West Virginia and the District of Columbia, Howard University is the only medical school which admits Negroes. This border area has a Negro population of 768,629 or 14.6 per cent of the total population. (Table I). Table II shows six medical schools in this area and 267 Negro medical students enrolled in 1947-48 as compared to a total enrollment of 1,632. All the Negro medical students of this area were enrolled at Howard University College of Medicine. The other five schools do not admit Negroes.

The fact that the Howard University College of Medicine, with a predominantly Negro enrollment, is in this area makes the ratio of Negro medical students to total medical students in the area come more nearly paralleling the ratio of Negro population to the total population.

Since its beginning in 1869 the College of Medicine of Howard University has enrolled both white and Negro students. It is the only one of the three medical schools of the Nation's

TABLE II

POPULATION-PHYSICIAN RATIOS AND MEDICAL GRADUATES IN THIRTEEN SOUTHERN STATES, THE BORDER SOUTHERN AREA, THE NEW ENGLAND STATES, MIDDLE ATLANTIC STATES, EAST NORTH CENTRAL STATES, AND THE WEST NORTH CENTRAL MOUNTAIN AND PACIFIC STATES

State	Total Number of Persons Per Physician in State 1940[1]	Total Number of Persons Per Physician in State 1948[2]	Number Negro Persons Per Physician in State 1942[3]	Number Negro Persons Per Physician in State 1948[5]	Total Medical Graduates 1947-48[6]	Negro Medical Graduates 1947-48[7]
South	1,060	1,146	5,832	6,203	1,238	58
Virginia	1,018	1,262	3,614	4,453	114	0
North Carolina	1,383	1,556	5,772	5,739	114	0
South Carolina	1,505	1,706	12,152	12,561	53	0
Georgia	1,222	1,158	7,134	7,384	114	0
Florida	925	1,035[a]	6,049	4,403	0	0
Kentucky	1,115	1,224	1,964	2,323	144	0
Tennessee	1,245	1,078	2,068	2,352	211	58[4]
Alabama	1,523	1,036	7,866	8,519	0	0
Mississippi	1,635	1,525	18,527	18,132	0	0
Arkansas	1,161	1,104	8,320	10,830	55	0
Louisiana	1,006	743	8,666	10,052	177	0
Oklahoma	993	984	2,378	1,701	62	0
Texas	1,025	1,046	5,569	7,828	194	0
Total	.....	.....	.....	.....	1,238	58
Border States and the District of Columbia	628	691	1,494	1,808	374	64
*Delaware	803	876	3,986	3,341	0	0
*Maryland	619	719	2,581	3,496	155	0
West Virginia	1,099	1,035	2,265	1,827	0	0
District of Columbia	382	370	743	1,029	219	64
Total	.....	.....	.....	.....	374	64
New England	619	658	1,845	1,668	333	2
Maine	951	878	0	0	0	0
New Hampshire	876	751	0	548**	0	0
Vermont	778	831	0	0	40	0
Massachusetts	608	598x	1,787	1,496	238	1
Rhode Island	770	680	1,837	1,870	0	0
Connecticut	688	685	1,832	1,910	55	1
Total	.....	.....	.....	.....	333	2
Middle Atlantic	592	520	1,997	2,564	1,363	4
New York	511	496	2,123	2,723-	742	3*
New Jersey	704	366	1,555	2,386	0	0
Pennsylvania	765	697	2,137	2,487	621	1
Total	.....	.....	.....	.....	1,363	4
East North Central	749	867	1,516	1,709	1,137	7
Ohio	770	907	1,865	2,222	225	1
Indiana	883	946x	1,742	1,852	84	1
Illinois	683	711x	1,246	1,615	408	1
Michigan	855	1,032	1,590	1,339	192	4
Wisconsin	922	943	1,105	1,203	228	0
Total	.....	.....	.....	.....	1,137	7
West North Central	812	850	1,150	1,265	619	0
Minnesota	819	730	3,309	3,920	140	0
Iowa	867	967	1,284	1,838	57	0
Missouri	758	718	1,002	1,111	210	0
North Dakota	1,256	1,236	0	0	0	0
South Dakota	1,276	1,396	0	0	0	0
Nebraska	834	876	1,771	934	132	0
Kansas	871	1,093	1,760	2,024	80	0
Total	.....	.....	.....	.....	619	0

TABLE II (*Continued*)

Mountain	834	734	2,022	3,283	88	0
Montant	1,058	786	0	0	0	0
Idaho	1,271	706	0	0	0	0
Wyoming	1,105	1,233	0	0	0	0
Colorado	684	619	1,218	2,136	52	0
New Mexico	1,043	1,300xx	1,555	5,139	0	0
Arizona	890	664	2,999	3,320	0	0
Utah	995	658	0	0	36	0
Nevada	766	728	0	0	0	0
Total	.....	.....	.....	.....	88	0
Pacific	625	624	1,814	1,374	335	2
Washington	830	1,032	1,485	3,316	0	0
Oregon	781	1,016	2,565	3,252	65	0
California	630	538	1,828	1,319	270	2
Total	.....	.....	.....	.....	335	2

[1]United States Bureau of Labor Statistics Bulletin No. 863.
[2]Calculated from Census Bureau's 1948 Estimates of Population and Number of Physicians in State as reported by State Health Officer or State Board of Medical Examiners. Where 1948 Estimate of Physicians was not available (Florida) the American Medical Association figure for 1940 was used.
[3]Cornely, Paul B., M.D.—*Journal of the American Medical Association*, V. 124:826 (1944).
[4]Graduates from Meharry Medical College at Nashville.
[5]Based upon estimated Negro Population for 1948 and number of Negro Physicians in 1948 as ascertained from State Health Officers, State Board of Medical Examiners, National Medical Association or County Negro Medical Association. The estimate of 1948 Negro population obtained by using 1940 percentage of total and securing percentage of 1948 estimate of total population to secure Negro Population for 1948.
[6]*Journal of the American Medical Association*, 137:27-28, S 1948.
[7]Communication from Michael J. Bent, M.D., Dean, Meharry Medical College, Nashville, Tenn.
*Report of total physicians in 1948 for Delaware and Maryland not available. 1940 report of total physicians used instead.
**New Hampshire in 1948 had a total Negro population of 548 and one Negro physician.
x1940 record of physicians .
xx1940 Census of Physicians.

there were 5,487 medical graduates in 1947-48, of this number 137 were Negroes. All things else being equal and there being no racial discrimination, one might have expected on the basis of the percentage of Negroes in the total population that there would have been 521 Negro medical graduates in 1947-48, instead of 137. It will also be noted from Table I, that 122 of the 137 Negro medical graduates were from the South and the border area (all from Howard and Meharry) leaving only 15 Negro medical graduates from the remainder of the United States. Stating the same observation in a way not shown by the table, Howard and Meharry medical schools together graduated 122 Negroes as Doc-

only 15. Those other 69 schools might have been expected to have graduated 399 Negroes in 1947-48. There are evidences of some slight improvement in the prospects of Negroes being able to study medicine at schools other than Howard and Meharry. In 1947-48 there were 27 medical schools exclusive of Howard and Meharry with one or more Negroes enrolled, in 1948-49 the number increased to 36. The University of Michigan has for a number of years evidenced a more liberal policy than any of the medical schools exclusive of Howard and Meharry Medical Colleges. For some time the University of Michigan has had ten or more Negroes in the medical school, more than any single school

Medical College have slightly better than 2 per cent Negro students in their respective enrollments. The College of Medical Evangelists and Wayne University are next with 1.8 per cent and 1.7 per cent respectively. In 1948-49 there were 119 Negro students enrolled in medical schools other than in Howard and Meharry as compared with 93 in 1947-48. The increase is slight but an increase nevertheless and an indication of a more democratic trend. This change will have an influence upon increasing the number of Negro physicians. Table III shows 38 four-year medical schools including Howard and Meharry, which have one or more Negroes enrolled. These have a total enrollment of 12,825 of which 614, or 4.7 per cent, are Negroes. There yet remains 32 four-year medical schools with not a single Negro enrolled among their 9,420 students. Many of these thirty-two schools maintain an admitted policy of exclusion. The others claim that they do not discriminate against Negroes but that they have no qualified Negro applicants. These thirty-two schools could make a valuable contribution to the making of medical education in the United States a truly democratic administrative and educational procedure.

Table II shows the ratio of Negro persons to Negro physicians in the states and sections of the country. In adopting this method of depicting a shortage of Negro physicians the writer entertains no concept that the Negro physician should serve only Negro patients nor that Negro patients that physicians should serve patients without regard to race or creed and that patients should be served by physicians without regard to the physician's race or creed. In using the ratio of Negro population to the population as a whole and the ratio of Negro physicians to the total number of physicians the concept is that the Negro should have in the medical service a sufficient number of physicians to enable him to carry his full share of the responsibility for caring for the sick and safeguarding the nation's health. As long as there are distinguishable minorities singled out as such, they should all be afforded opportunities to efficiently carry their proportionate share of the responsibility for the community well-being and development in all fields of service.

While there is one physician for every 755 person in the United States, as a whole, the distribution in various sections of the country results in quite a different picture for given sections. Whatever the picture in any section, however, it will be seen from the tables that the picture for the supply and distribution of Negro physicians is not as good. For example, Mississippi and South Carolina have the worse picture as far as the supply of physicians is concerned. Mississippi had in 1948 one physician for each 1,525 persons and South Carolina 1,706 for each physician. In these states with large Negro populations there are 18,132 Negroes for each Negro physician in Mississippi and 12,561 Negroes for each Negro physician in South Carolina. For the United States

TABLE III

DISTRIBUTION OF PHYSICIANS, ENROLLMENT OF MEDICAL STUDENTS

	Total Physicians		Negro Physicians		Negro Medical Students Enrolled in Medical Schools of Area		No. Medical Schools
	1940	1948	1942	1948	1947-48	1948-49	
South (13 states)	34,916	34,814	1,588	1,572	234	233	21
Virginia	2,889	2,400	183	168	0	0	2
North Carolina	2,740	2,387	170	178	0	0	1[b]
South Carolina	1,402	1,167	67	68	0	0	1
Georgia	2,825	2,700	152	147	0	0	2
Florida	2,276	2,276[x]	85	145	0	0	0
Kentucky	2,761	2,302	109	91	0	0	1
Tennessee	2,908	2,922	246	233	234[z]	232[z]	3
Alabama	2,075	2,749	125	116	0	0	1
Mississippi	1,497	1,391	58	57	0	0	1[b]
Arkansas	1,829	1,744	58	44	0	1[a]	1
Louisiana	2,464	3,467	98	92	0	0	2
Oklahoma	2,352	2,400	71	100	0	0	1
Texas	6,898	6,909	166	133	0	0	3
Total	34,916	34,814	1,588	1,572	234	233	21
Border Area to South (3 States and D. C.)	7,404	7,607	430	425	267	264	6
Delaware	339	339[x]	9	12	0	0	0
Maryland	2,988	2,988[x]	117	102	0	0	2
West Virginia	1,834	1,850	52	65	0	0	1
Dist. of Columbia	2,243	2,430	252	246	267[y]	264[y]	3
Total	7,404	7,607	430	425	267	264	6
New England	13,619	14,130	55	68	11	17	6
Maine	922	1,025	0	0	0	0	0
New Hampshire	656	729	0	1	0	0	1[b]
Vermont	523	450	0	0	0	0	1
Massachusetts	7,889	7,889[x]	31	41	8	14	3
Rhode Island	961	1,100	6	6	0	0	0
Connecticut	2,598	2,937	18	20	3	3	1
Total	13,619	14,130	55	68	11	17	6
Middle Atlantic	46,519	57,241	635	533	33	46	15
New York	27,177	29,000	269	222	23	30	9
New Jersey	5,813	12,921	146	109	0	0	0
Pennsylvania	13,529	15,320	220	202	10	16	6
Total	46,519	57,241	635	533	33	46	15
East North Central	35,523	34,428	705	707	35	36	12
Ohio	9,318	8,600	182	172	6	5	3
Indiana	4,132	4,132[x]	70	76	4	5	1
Illinois	12,188	12,188[x]	311	263	8	11	4
Michigan	6,362	6,000	131	185	17	14	2
Wisconsin	3,523	3,508	11	11	0	1	2
Total	35,523	34,428	705	707	35	36	12
West North Central	16,639	16,423	305	294	2	6	10
Minnesota	3,527	4,029	3	3	0	0	1
Iowa	3,084	2,710	13	10	1	1	1
Missouri	5,297	5,500	244	231	0	0	2[c]
North Dakota	518	453	0	0	0	0	1[b]
South Dakota	508	446	0	0	0	0	1[b]
Nebraska	1,635	1,485	8	15	1	2	2
Kansas	2,070	1,800	37	35	0	3	1
Total	16,639	16,423	305	294	2	6	10
Mountain	4,973	6,147	18	13	0	1	2
Montana	537	650	0	0	0	0	0
Idaho	423	750	0	0	0	0	0
Wyoming	274	223	0	0	0	0	0
Colorado	1,964	1,880	10	6	0	1	1
New Mexico	439	439[x]	8	1	0	0	0
Arizona	594	1,000	5	6	0	0	0

TABLE III—(Continued)

Pacific	15,570	22,642	74	141	12	10	5
Washington	2,200	2,408	5	3	0	0	0
Oregon	1,461	1,600	1	1	1	2	1
California	11,909	18,634	68	137	11	8	4
Total	15,570	22,642	74	141	12	10	5
United States	175,163	193,432	3,810	3,753	594	613	77

(x) 1940 American Medical Association Report. 1948 not available; (y) Howard University; (z) Meharry College; (a) University of Arkansas; (b) Two year Basic Science Schools. (c) One of these is a two year Basic Science School.

TABLE IV

TOTAL POPULATION, TOTAL PHYSICIAN-RATIOS AND NEGRO POPULATION NEGRO PHYSICIAN-RATIOS FOR THIRTEEN SOUTHERN STATES

	Total 1948 Population	1948 Total Physicians	Number Persons Per Physician For Total Population	1948 Negro Population	1948 Negro Physicians	Negro Population Per Negro Physician
South	39,924,000	34,814	1,146	9,752,326	1,572	6,203
Virginia	3,029,000	2,400	1,262	748,163	168	4,453
North Carolina	3,715,000	2,387	1,556	1,021,625	178	5,739
South Carolina	1,991,000	1,167	1,706	854,139	68	12,561
Georgia	3,128,000	2,700	1,158	1,085,416	147	7,384
Florida	2,356,000	2,276[1]	1,035	638,476	145	4,403
Kentucky	2,819,000	2,302	1,224	211,425	91	2,323
Tennessee	3,149,000	2,922	1,077	547,926	233	2,352
Alabama	2,848,000	2,749	1,036	988,256	116	8,519
Mississippi	2,121,000	1,391	1,524	1,043,532	57	18,132
Arkansas	1,925,000	1,744	1,103	477,400	44	10,850
Louisiana	2,576,000	3,467	743	924,784	92	10,052
Oklahoma	2,362,000	2,400	984	170,064	100	1,701
Texas	7,230,000	6,909	1,046	1,041,120	133	7,828
Total	39,924,000	34,814	(1,146)	9,752,326	1,572	(6,203)

[1]Number of Physicians reported by Americal Medical Association for 1940. 1948 figure not available.

North Central section and the Pacific section present the best picture in the tables. In the West North Central section, there are 1,265 Negroes for each Negro physician and 1,374 Negroes for each Negro physician in the Pacific section.

Comparing the figures for 1948 with those for 1942, the number of Negro persons per physician is greater in 1948 instead of less except in the Pacific area. The improvement in the Pacific area is due to the large increase in the number of Negro physicians in California. The number increased from 68 to 137 (Table III). tion has increased but the number of Negro physicians has not increased proportionately, if at all. With only 137 Negro medical graduates in 1947-48 and approximately the same in 1948-49 it is apparent that there must be a decided increase if the ratio of Negro physicians to Negro population is to show a reasonable approximation to the rate of physicians to population in any section of the country.

There are nine states with a Negro population totaling 7,622, ranging from 175 in North Dakota to 1,800 in Maine, in which there is not a Negro physician. Two of these states are in

TABLE V

PER CENT OF NEGROES IN TOTAL ENROLLMENT OF MEDICAL SCHOOLS AND FOR STATES ABOVE ZERO PER CENT

	1947-48	Total Enrollment 1947-48	Negro Students Enrolled 1948-49	Per cent Negro Enrollment 1948-49*
Arkansas	274	0	1	0.3
University of Arkansas School of Medicine	274	0	1	0.3
California	1,095	11	8	0.7
Univ. of California Medical School	283	2	2	0.7
College of Medical Evangelists	319	9	6	1.8
Colorado	233	0	1	0.4
Univ. of Colorado School of Medicine	233	0	1	0.4
Connecticut	222	3	3	1.3
Yale University School of Medicine	222	3	3	1.3
District of Columbia	958	264	263	27.4
Howard University	274	264	263	95.9
Illinois	1,663	8	11	0.6
Northwestern Univ. Medical School	520	1	1	0.2
Stritch Schl. of Med., Loyola Univ.	277	1	1	0.3
Univ. of Chicago Schl. of Medicine	232	0	1	0.4
Univ. of Illinois Coll. of Medicine	634	6	8	1.2
Indiana	396	4	5	1.2
Indiana Univ. School of Medicine	396	4	5	1.2
Iowa				
State Univ. of Iowa Coll. of Medicine	278	1	3	1.0
Kansas	308	0	3	0.9
Univ. of Kansas School of Medicine	308	0	3	0.9
Massachusetts	1,133	8	14	1.2
Boston Univ. School of Medicine	235	3	5	2.1
Harvard Medical School	504	3	6	1.1
Tufts College Medical School	394	2	3	0.7
Michigan	702	17	14	2.0
Univ. of Michigan Medical School	476	10	10	2.1
Wayne Univ. College of Medicine	226	7	4	1.7
Nebraska	537	1	2	0.3
Creighton Univ. School of Medicine	244	1	2	0.8
New York	2,996	23	30	1.0
Albany Medical College	182	0	1	0.5
Long Island College of Medicine	404	2	4	1.0
University of Buffalo Schl. of Med.	273	2	3	1.1
Columbia University College of Physicians and Surgeons	432	5	4	0.9
Cornell University Medical College	315	3	4	1.2
New York Medical College	446	2	5	1.1
New York Univ. College of Medicine	487	6	6	1.2
Univ. of Rochester Schl. of Medicine	267	3	2	0.7
Syracuse Univ. College of Medicine	190	0	1	0.5
Ohio	950	6	5	0.5
Western Reserve Univ. Schl. of Medicine	312	0	1	0.3
Ohio State Univ. College of Medicine	317	6	4	1.2
Oregon				
Univ. of Oregon Medical School	270	1	2	0.7
Pennsylvania	2,425	10	16	0.6
Jefferson Medical College	621	0	1	0.1
Temple Univ. School of Medicine	459	3	5	1.0
Univ. of Pennsylvania Schl. of Med.	479	1	2	0.4
Univ. of Pittsburgh Schl. of Med.	303	3	4	1.3
Woman's Medical Coll. of Penn.	158	3	4	2.5
Tennessee	949	231	232	24.4
Meharry Medical College	231	231	232	100.0
Wisconsin	628	0	1	0.2
Marquette Univ. School of Medicine	350	0	1	0.2
Total	19,895	599	614	4.7%

West North Central section and five in the Mountain section, (Table III). Five of these nine states, where there is no Negro physician, are without a medical school. In addition to these five states, there are seven others or a total of twelve states without a medical school. These twelve states had a combined population in 1940 of 12,097,244 of whom 819,799 were Negroes and a total of 282 Negro physicians or one Negro physician to each 2,906 Negro persons. Three of these twelve states have populations greater than a million persons, New Jersey leading with a population of more than four million. Florida now has 145 Negro physicians serving its population and New Jersey has 109, but neither state has a facility for relieving the physician shortage, although they have a combined population of about 6,000,000. New Jersey, however, now has the best physician population ratio, 1 to 366. (Table IV). As far as the Negro is concerned, the ratio in New Jersey is 1 to 2,386. Florida is third best among the Southern states with a ratio of 1 physician to each 1,035 of the population. As to the Negro, however, the ratio is 1 to 4,403. (Table II. The state of Washington is not included in this tabulation, but a medical school has now been established as a part of the University of Washington.)

Available Internships

There was a time when the number of Negro graduates in medicine was much greater than the available opportunities for serving an internship tion has very markedly improved. (See Table VI). There are more approved internships in Negro hospitals and there are more non-Negro hospitals which accept Negro physicians as internes. In July 1949 the Gallinger Municipal Hospital of Washington, D. C., will have its first Negro Interne.

TABLE VI

Available Internships for Negro Physicians in Approved Hospitals

	Hospital	No. of Beds*
1.	Cleveland City Hospital	1,135
2.	Columbus Hospital, New York	300
3.	Coney Island Hospital, Brooklyn	300
4.	Cook County Hospital, Chicago	3,505
5.	Cumberland Hospital, Brooklyn	400
6.	Detroit Receiving Hospital, Detroit	633
7.	Fajarda District Hospital, Puerto Rico	324
8.	Flint Goodridge Hospital, New Orleans	117
9.	Freedmen's Hospital, Washington, D. C.	498
10.	Gallinger Municipal Hospital, Washington, D. C.	1,536
11.	Greenpoint Hospital, Brooklyn	300
12.	George W. Hubbard Hospital, Nashville	181
13.	Hackensack ospital, Hackensack	300
14.	Harlem Hospital, New York	697
15.	Homer G. Phillips Hospital, St. Louis	767
16.	Jersey City Medical Center, Jersey City	1,500
17.	ansas City General No. 2, Kansas City	286
18.	Kate Bitting Reynolds Memorial Hospital, Winston-Salem	224
19.	Lincoln Hospital, Durham	122
20.	Los Angeles County Hospital, Los Angeles	3,624
21.	Mercy Hospital, Baltimore	335
22.	Mercy Douglas Hospital, Philadelphia	120
23.	Percy Jones General Hospital (Army), Battle Creek	2,346
24.	Philadelphia General Hospital	2,560
25.	Provident Hospital, Baltimore	145
26.	Provident Hospital, Chicago	208
27.	St. Agnes Hospital, Raleigh	134
28.	St. Mary's Infirmary, St. Louis	175
29.	Sydenham Hospital, New York	251

*Journal of the American Medical Association

Residencies and Assistant Residences

The openings for appointments to assistant residencies and residencies in approved hospitals are too few to meet the needs of Negro physicians. The number of physicians seeking training beyond the internship has been steadily increasing but there are not sufficient openings. Freedmen's Hospital, the teaching hospital of the College of Medicine of Howard University and the Homer G. Phillips Hospital of St. Louis offer the major opportunities for residency training. Many of the hospitals listed in Table VI as approved for internships offer limited residency opportunities for Negro physicians. Some of the U. S. Marine Hospitals have been approved for residency training in some fields. The Marine Hospital at Boston has for the last few years had one Negro physician on its assistant resident staff. The Cleveland City Hospital has for several years afforded opportunities for Negro physicians in its residency training program.

Specialty Certification

As a result of improved opportunities for Negro physicians in graduate training, the number of certified specialists has increased from less than twenty-five in 1938 to more than one hundred in 1949. Negro physicians have been examined and certified by the specialty boards in all of the major specialties. The more than one hundred Negro specialists are certified by the boards of: Internal Medicine, Surgery, Otolaryngology, Ophthology, Psychiatry and Neurology, Dermatology, Pathology, Obstetrics and Gynecology.

Summary

Although there are about 193,432 licensed physicians in the United States, about 3,753 of whom are Negro physicians, there is need for many more physicians to care for the civilian population and to meet the increased demands of the military services, the United States Public Health Service and various expanding state and municipal services. In addition to the shortage of physicians there is a maldistribution of physicians. Although there is one physician for each 755 people in the United States, some states have one physician for more than 1,000 people, the highest being 1,706 in South Carolina. Both the shortage and the maldistribution are more acute as far as the Negro physician is concerned. There appears to be a slight decrease in the number of practicing physicians in 1948 as compared with the number reported in 1942. In 1942 there were 3,810, in 1948 there appears to be 3,753. The Negro population has increased from 12,865,518 in 1940 to an estimated 13,818,504 in 1948. Relating the number of Negro physicians to the Negro population there is one Negro physician for each 3,681 Negro persons in the United States. The rate in 1942 was 1 to 3,376. In the thirteen Southern states there is one Negro physician to each 6,203 Negro persons. In Mississippi the ratio was 1 Negro physician to each 18,132 Negro persons and 1

physicians and to improve the distribution better opportunities must be provided for medical education for Negroes and better professional opportunities for qualified Negro physicians. Elimination of racial discrimination against Negroes is essential to the betterment of the educational and professional opportunities. Medical schools which exclude Negroes because of race should remove this barrier and accept qualified Negroes for training. It is especially important that the medical schools of the South and the border areas including the District of Columbia revise their policies in this respect. Racial discrimination which hampers the full development of the Negro physician in his profession contributes to both shortage and maldistribution.

There are evidences of improvement of opportunities in some areas but much remains to be desired. A few more Negroes are gaining admission to medical schools other than Howard and Meharry. More opportunities for good internships have developed. Better opportunities for both graduate and postgraduate medical education are developing. The evidences of better opportunities are limited almost entirely to the North, and West rather than to the South, where about ten million of the thirteen million Negroes live.