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The evolution of healthcare for Louisville's African American community, 1865-1990.

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<https://doi.org/10.18297/etd/199>

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THE EVOLUTION OF HEALTHCARE FOR LOUISVILLE'S AFRICAN AMERICAN
COMMUNITY:

1865-1990

By

Angela Calloway

B.S.N. Indiana University Southeast, 1993

M.A. University of Louisville, 2007

A Dissertation

Submitted to the Faculty of the

School of Nursing of the University of Louisville

in Partial Fulfillment of the Requirements

for the Degree of

Doctor of Philosophy

School of Nursing

University of Louisville

Louisville, Kentucky

August 2013

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A Dissertation Approved on

July 2, 2013

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DEDICATION

This dissertation is dedicated to my parents

Mr. Loran Roop, Jr

and

Mrs. Cathy N. Roop

who have taught me to persevere.

Also,

to my children

Uriah, Naomi, Cyrus, Mahalah and Zoltan

who mean the world to me.

ACKNOWLEDGEMENTS

I would like to thank all members of my dissertation committee. Each one has touched me in a special way. To my chair, Dr. Vicki Hines-Martin, thank you for keeping me in order. To Dr. Debbie Armstrong, thank you for being a positive, smiling face to encourage me. To Dr. Celeste Shawler, thank you for grounding me, calming me and helping me to see the forest despite the trees. Dr. Cate Fosl, thank you for encouraging me to pursue my love of historical research, coaching and prompting me all along the way. I would like to make special thanks to Dr. J.B. Hudson who is no longer with us in body. His love of history has always been an inspiration to me and his knowledge of local history has often left me captivated.

I would also like to give a very special thanks to Kathy Johnson, of the Kornhauser Library Archives for helping get started and guiding me through the archives collection. Finally, I am very grateful to the individuals who allowed me to record and use their oral histories.

ABSTRACT

THE EVOLUTION OF HEALTHCARE FOR LOUISVILLE'S AFRICAN AMERICAN COMMUNITY: 1865-1990

Angela K. Calloway

July 2, 2013

It is well documented that inequality in the delivery of health care exists within the U.S. (Smedley, Stith & Nelson, 2003; Trivedi, Zaslavsky, Schneider, & Ayanian, 2006). Historically, our health care system was a segregated one in which white Americans enjoyed one system of health care—a more privileged one-- while black Americans experienced another, supported by law and custom. Laws changed after the Civil Rights Act of 1964 but disparate practices lingered. Although there have been studies about the historical picture of segregated health care available to black Americans (Byrd & Clayton, 2000; Savitt, 2007), there is a lack of research about the evolution of that health care system to its current state as a more fully integrated one.

The purpose of this study was to examine the evolution of health care for the black community of Louisville, Kentucky, a mid-size city of approximately 800,000 citizens situated along the Ohio River which historically served as a gateway to the south. The study *aims* were to describe 1) health care delivery over time, 2) attitude assumptions, perceptions and experiences of health care providers, 3) activities that influenced health care integration and 4) the quality of health care for black Louisvillians

pre- and post- integration.

An historical research method guided by Critical Race Theory was used to describe the perspective of those who were marginalized within this society. Archival material and oral histories framed by secondary literature on this topic served as data.

Study findings confirm the presence of overt stereotypes and bias that perpetuated the segregated health care system historically. Motivation for change stemmed more from the white health care providers' gain than from an internal change perspective regarding the Black citizens' right to comparable care within an integrated system. However, the overt stereotypes that had been easily identified in archival records prior to integration became less visible after integration of the health care system. Even as overt discrimination declined, study findings also indicate that disparate treatment and caregiver bias remained throughout the time period explored in this study.

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CHAPTER I: INTRODUCTION AND SIGNIFICANCE

Background of the Problem

Research in the last decade has identified that the quality of care delivered to the United States black population is poorer than that delivered to the white population (Smedley, Stith & Nelson, 2003). While such factors as insurance coverage, socioeconomic levels and access to care (Marmot, 2005) are recognized influences on this disparity, studies suggest that they are not the *only* influences on disparities in health status and health care services. Most importantly, the influence of health care providers' socially constructed perceptions about black Americans has served as an important barrier. (Benkert & Peters, 2005; Green, Carney, Pallin, Ngo, Raymond, Iezzoni, & Banaji, 2007). Historically, the perceptions of white health care providers played a role in delivery of care and segregation of care to black American patients (Savitt, 2007).

Over the last century, the U.S. health care system has undergone significant changes. What began as a racially segregated system is now a racially integrated health care system throughout the United States. Progress toward an integrated health care system was influenced by many factors including legislation, historical events, socioeconomic forces and geographic setting, especially for the black American population (Byrd & Clayton, 2000; Gilman, 1985; Gordon, 2003; Savitt, 2007).

As with other U.S. cities, Louisville, Kentucky has seen similar change in the development and organization of its health care system as it progressed from a segregated to an integrated one with its own unique changes and challenges.

Statement of the Problem

A growing body of research has identified the role of stereotype and bias in provision of healthcare and subsequent health disparities within our health care system (Benkert & Peters, 2005; Green et al., 2007; Hugenberg, Bodenhausen, & McLain, 2006; Peters, 2004). In addition, there have been historical studies about the segregated health care available to black Americans (Byrd & Clayton, 2000; Savitt, 2007). For most of the periods following the end of the Civil War to the mid-20th Century, the availability of many goods and services was restricted to individuals according to race. This was true of healthcare. While whites enjoyed one system created for their needs, blacks were left to create their own healthcare system to address theirs. For example, by the late 1920s the segregated healthcare system was so entrenched into the American custom that only 1 per cent of all U.S. hospitals actually catered to the needs of black patients (Stevens, 1999). The process of replacing that segregated system with a desegregated system (one that seems to be still replete with inequalities) needs inspection. Exploration of historic events, socioeconomic factors, and healthcare provider views regarding health and health care and the consequences of these factors on the treatment of black patients as compared to white patients is a phenomenon that begs for discovery and examination. To better comprehend the context for today's health care system, in any community, an historical perspective is foundational. Understanding where we have been is instrumental to planning where science and nursing need to go to better address health disparities and

disparate healthcare practices.

Purpose of the Study

In 1905, philosopher George Santayana poignantly wrote, “Those who cannot remember the past are condemned to repeat it” (Santayana, 1998, p.104). By recounting the historic changes in moving away from segregation in health care, health care provision may be better understood. Therefore, the **purpose** of this study was to chronicle the evolution of health care provided to the black community in the city of Louisville, Kentucky from 1865, just after the Civil War, until approximately 1990. Although the conclusion of the Civil Rights Movement cannot be finely pinpointed (K’Meyer, 2009), peering into events up through 1990 allows ample time for the premise of the Civil Rights Act to be implemented across the healthcare system. By delineating the perceptions and assumptions that influenced segregated care and the methods adopted to ameliorate those assumptions in the integrated health care system, we are better able to understand the paths that have led to the current health disparity that still exists for black patients within this setting. The study was guided by the following research questions.

Research Questions

1. What health care was available to Louisville’s black community from 1865 to 1990?
2. What historical evidence documents health care providers’ attitudes and assumptions about black Americans throughout the decades prior to and subsequent to the Civil Rights Act of 1964?
3. What were the factors that motivated Louisville’s white healthcare providers to

desegregate?

4. What does the historical evidence indicate about the quality of the care received by African Americans during the decades before and after health care integration?

Importance of the Study

Research has shown that the quality of care delivered to the United States black population is poorer than that delivered to the white population and extends across the spectrum of health care (Allard & Maxwell, 2009; Kruper et al., 2011; Norris & Nissenson, 2008; Plechter, Kertesz, Kohn & Gonzales, 2008; Smedley, Stith & Nelson, 2003; Trivedi, Zaslavsky, Schneider & Ayanian, 2006). Historically, the case of the Tuskegee Syphilis Study (U.S. Department of Health and Human Services, 2013) has often been cited as evidence of inequality within the health care system. In this study, black men with syphilis were recruited by public health officials for a study to assess the development of the disease in black men in comparison to white men. The men were not told that they had syphilis, only that they were being treated for “bad blood”. They did not receive curative treatment. Even when penicillin became widely available and successful at treating the disease, the men were denied treatment and public health workers on the study went so far as to stop a few who did seek treatment and return them to the study. Many of the men died from the disease and were compensated with funeral expenses. The study lasted forty years (1932-1972) before it was exposed through the media and abruptly stopped (Jones, 1981). The Tuskegee Syphilis Study, along with other ethically flawed studies, led to the enactment of the National Research Act in 1974 to prevent unethical treatment of participants in research (U.S. Department of Health and Human Services, 2013).

Since the Institute of Medicine's landmark report on health disparities (2002), disparities continue to exist within healthcare for black Americans. Pregnant black women are more likely to have placental disorders and deliver preterm, low birth-weight babies than are white pregnant women (Lorch, Kroelinger, Ahlberg, & Barfield, 2012). Furthermore, stillbirth rates among black babies are twice as high as among white babies (Hogue et al., 2013). After birth, black infants have a higher mortality rate in the first year of life than do white infants. Between the ages of 24-65 black Americans have higher mortality rates than white Americans. Black Americans have greater incidence of diseases such as hypertension, cardiovascular disease, obesity, diabetes, and certain types of cancer and these diseases start earlier in life for black Americans, and with more severe complications, than they do for white Americans (Institute of Medicine, 2012). Furthermore, when seeking medical care, black Americans are met with providers who are less likely to identify their disease when compared to white patients, and spend less time with them, leading to inadequate management of their care (Benkert & Peters, 2005; Klonoff, 2009).

More research needs to be conducted that helps identify the etiology of these disparities and findings from this study may add to that body of knowledge that seeks to place into context the quality of care experienced by all Americans, black and white and serve as a foundation for change.

Scope of the Study

In this study, the investigator limited the inquiry to a case study of one city situated barely within the Southern region of the United States. Louisville, Kentucky is a mid-size city of approximately 800,000 citizens situated along the Ohio River which

serves as the gateway to the south from the Northern/Midwest region. In its early days the city was a hub of shipping activity, with its prime location along the Ohio River (Meyer, 1989). More recent years has seen its transformation into an industrial city with healthcare as one of its primary products (Combs, 2013).

In this study, the social, legal and political influences which motivated racial segregation and desegregation of Louisville's health care system were identified through review of archival records and documents, and oral history narratives. This study described health care delivery, attitudes and assumptions of health care providers, activities that influenced health care integration and quality of health care pre- and post-integration. Findings from this study identified racial barriers as well as psychosocial and socioeconomic factors that supported barriers experienced by the black community. This study was limited to the period of 1865 to 1990.

Definition of Terms

1. Evolution - the development or progression of a phenomenon, entity or mechanism, the focus for this study was the health care system as experienced by African Americans, over the selected period of time.
2. Health care - "health care" or "care" was defined as any service provided that prevents, diagnoses or treats a physical or mental ailment in an individual or population. The "care" may be provided within a hospital or community setting.
3. Health care providers - any individual or group of individuals who are trained provide health care services.
4. Health care quality – as defined by the Institute of Medicine's 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century* is "the

degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with existing professional knowledge” (Institute of Medicine, 2001, p. 232).

5. Black Americans - those individuals who descend from persons of African descent who hold American citizenship. Specifically, those individuals descended from those African slaves brought to the United States. Although those individuals who may have origin in Africa and habitation in the United States *after* the period of slavery are not excluded, these individuals constitute a smaller portion of the population being studied (those having descended from slaves) (Capps, Fortuny, Zimmerman, Bullock, & Henderson, 2006; Capps, Fix, & McCabe, 2011). Furthermore, because Americans, during the identified period, recognized the “one drop rule” (Wright, 1994), or the societal assumption that “one drop” of black African blood categorized any individual as “black” or “African American” despite external characteristics (Sweet, 2005), this definition will be followed in this study. Furthermore, this term transposes with the terms “negro” and “colored” that were found most often in the archival material.
6. White Americans- any individual being identified as not ‘black’ and not fitting any specific ethnic group that Europeans would consider ‘non-white’ (Dee, 2004). This would exclude all African, Middle-Eastern, Asian, and Hispanic ethnic groups as white, but Jews, along with all European descended individuals, would be included.
7. Segregation (and desegregation)- in this study refers to racial segregation, or a practice of separating individuals by race into separate facilities within an

institution (*Encyclopedia Britannica*, 2013). Segregation, a custom that reserved many privileges for whites only, became law in many former slaveholding states from the 1890s through the 1910s, and was only outlawed in the post-World War Two era after decades of legal activism and social protest. Desegregation, as it is used in this study, is the reversal (in theory) of that practice.

CHAPTER 2: REVIEW OF LITERATURE

Introduction

In this chapter, a synopsis of the findings from the literature pertaining to health and health care for black Americans will be discussed. First, a discussion of the burden of disease experienced by black Americans will be delineated and an explanation of the socioeconomic influences on black Americans' health. This discussion will be followed by a review and critique of studies that explore the disparity in health care delivery in the United States by race. The influence that stereotypes and bias have played in the delivery of disparate care will be presented. Finally, a review of existing historical studies relating to these topics will be discussed. Having an understanding of the social, economic and political climate that permeated the country just after the Civil War and how the country interacted with the newly freed slaves sheds light on the attitudes of leadership by whites in the health care sector as well as the struggle of the black community in seeking health care during that period.

In addition to prior review of the literature, an additional literature search using Ovid (both Medline and CINAHL) and PubMed was conducted using search terms "African Americans," "race," "racism," "health disparities" and "social determinants of health" and "health care disparities". Two hundred and fifty-six articles spanning the years of 2010-2013 were retrieved. This number was further reduced to one hundred and eighteen by searching these articles for research only articles. Many of the articles described ongoing health disparities in a wide variety of areas. A scant few offered

anecdotes for the inequalities and only one evaluated the effectiveness of any intervention to relieve the disparities.

Of the 256 articles, seventeen were found to address the prevalence of disparities in care delivery when comparing black patients to white patients. These seventeen articles will be discussed in the literature review.

Burden of Disease among Black Americans

According to the Office of Minority Health (2009), black Americans have a mortality rate that is 1.5 times greater than white Americans. Black Americans are two times as likely to develop diabetes as are white Americans. Black males have seven times the rate of Human Immunodeficiency Virus (HIV)/Auto Immune Deficiency Syndrome (AIDS) as their white male counterparts. Black females have twenty-two times the rate of HIV and AIDS when compared to their white female counterpart. Black newborns are more likely to have low birth weight, be born pre-term and have an increased mortality rate that is more than twice that of white newborns. Cancer rates and deaths from cancer are higher among black Americans than white Americans. Black Americans are nearly twice as likely to suffer from a stroke as are white Americans (Office of Minority Health, 2009). They also have a significantly higher rate of all precursors to cardiovascular disease which include hypertension, obesity and diabetes (Keppel, Percy, & Wagener, 2002). In summary, across the spectrum of health concerns, black Americans have an increased burden of disease. Having a greater burden of disease increases the need for quality care among the black community.

Socioeconomic Influences

A significant portion of this disparity in health can be explained by

socioeconomic correlates that affect black Americans to a greater degree than whites. The psychological impact of being on the low end of the social gradient also plays a major role in health risks. Individuals in lower socioeconomic groups have been identified as experiencing significantly higher morbidity and mortality rates compared to those of higher income groups (Allen, Diez-Roux, Liu, Bertoni, Szklo, & Daviglius, 2011; Brondolo, Rieppi, Kelly, & Gerin, 2003; Marmot, 2005; Lindstrom, 2008; Vines, Baird, Stevens, Hertz-Picciotto, Light, & McNeilly, 2007; Williams & Neighbors, 2001). The causal factors for these health inequities among social groups remain unclear (Borerell, Muntaner, Benach, & Artazcoz, 2004; Carpiano, 2007; Clay, Roth, Safford, Sawyer & Allman, 2011). Black Americans are less likely to earn at least a high school diploma, have measurably lower median incomes than white Americans, are more likely to be in poverty, and are less likely to have insurance coverage than their white counterparts (Office of Minority Health, 2009). Greater understanding of the influence of socioeconomic factors combined with health care needs and health care delivery over time is needed. This study will add to that body of knowledge.

Disparate Care Delivery

The identification that black Americans have higher rates of disease and are affected by socioeconomic woes in greater proportion than whites is not the extent of the existing disparity. When black Americans enter the health care system, they experience additional disparity in care delivery. The Institute of Medicine (IOM, 2002) in its landmark report revealed that the quality of care experienced by non-white patients was lower than white patients across the various healthcare specialties. Despite controlling for factors such as socioeconomic status, insurance coverage and stage of disease, the

IOM found that minority patients (especially black Americans) were less likely to receive necessary treatment for many conditions. Black patients were less likely to receive angioplasties, coronary artery bypass grafts (CABG), mammograms or hip replacements when such treatments were warranted. Similar findings were noted in areas of cancer care, HIV treatment, renal disease and organ transplant. In some cases black patients were more likely to receive undesirable treatment such as amputations of one or more appendages for neuropathies (resulting from diabetes) and orchiectomies (removal of the testicles) for treatment of prostate cancer (Smedley, Stith, & Nelson, 2003).

Studies conducted since the IOM report (Smedley, Stith, & Nelson, 2003) reveal that the disparity in care delivery remains (Trivedi et al., 2006). African Americans continue to see differences in the care received for heart disease (Bagchi, Stewart, McLaughlin, Higgins & Croghan, 2011; van Ryn, Burgess, Malat, & Griffin, 2006), diseases of the kidney (Norris & Nissenon, 2008; Torrison, Foley, Gilbertson, Xue, & Collins, 2008), cancer treatment (Fagan, Moolchan, Lawrence, Fernander & Ponder, 2007; Kruper et al., 2011; Ragin, Langevin, Marzowki, Grandis & Taioli, 2011; Sun et al., 2011; Tian, Wilson & Zhan, 2011), pain management (Pletcher, Kertesz, Kohn, & Gonzales, 2008), women's health issues (Allard & Maxwell, 2009; Seng, Kohn-Wood, McPherson & Sperlich, 2011; Tian, Wilson & Zhan, 2011), and pediatric health issues (Falcone, Martin, Brown, & Garcia, 2008; Guerrero, Rodriguez & Flores, 2011; Howell, Holzman, Kleinman, Wang & Chassin, 2010; Hudson, Miller, & Kirby, 2007; Smith, Hatcher-Ross, Wertheimer, & Kahn, 2005; Shi & Stevens, 2005; Turner, Simpson, Scanlon & Quasney, 2011). Although studies have found that black Americans have a disproportionately higher rate of AIDS than do their white American counterparts, they

are less likely to be prescribed antiretroviral treatment (ART) and when prescribed, less likely to adhere to that therapy owing, in part, to their distrust in health care providers (Saha, Jacobs, Moore & Beach, 2010). Black Americans are less likely to utilize health care resources (Clay et al, 2011) and are also less likely to receive pneumonia prevention treatment increasing their morbidity and mortality associated with pneumonia (Hausmann et al., 2009). Finally, black Americans are more likely to be deceased before an ambulance arrives at their location in the field than are white Americans (David & Harrington, 2010) and those who are injured in a vehicle accident have a 50% less chance of survival while hospitalized than do white individuals (Haskins, Clark & Travis, 2013).

The United States Department of Health and Human Services *Healthy People 2010* goals (Healthy People, 2010) identified a priority to eliminate health disparities from our healthcare system. This goal continues to be a priority for Healthy People 2020. Addressing the vital issues of access to care, insurance coverage, early disease identification and treatment, as well as preventive methods are all avenues proposed to deal with health and health care inequities. To address similar concerns, the U.S. Veterans Administration (VA) undertook an initiative to implement measures to improve quality of care for all of their patients in 1995. Throughout the past two decades, the VA has instituted several quality measures, such as eye exams for diabetics, designed to help alleviate disparities in care. The VA has also monitored their employees for consistency in using these measures. A study conducted by Trivedi, Grebla & Wright (2011) analyzed the data of 1,126,254 veterans (955,047 white and 171,207 black) enrolled in the VA health care system across the United States from 2000-2009. Trivedi et al. (2011) found that although outcome measures such as eye exams for diabetics, colorectal cancer

screenings and blood pressure checks were improved overall, disparities continued to exist for black patients in these outcomes. The most significant disparities appeared in the areas of health management, for instance: uncontrolled blood pressures, uncontrolled LDL cholesterol, and uncontrolled blood sugars were noted to be significantly greater in the black patient sample than in the white patient sample. Although this study had a very large sample, its limitation was that it only analyzed data on ten quality outcomes. The findings suggested improvement in, but continued prevalence of, disparities in quality of outcomes for black patients in the VA system (Trivedi et al., 2011).

Even though there is research that supports the influence of genetics as an underlying cause in differing rates of some diseases when comparing Blacks and Whites (Frank, 2007; Kuzawa & Sweet, 2009; Kirstka et al., 2007). It is widely acknowledged that socioeconomic status has a significant impact on the health of individuals (Borell et al, 2004; Carpiano, 2007; Clarke, O'Malley, Johnston, & Schulenberg, 2009) and that black Americans are more likely than white Americans to be socioeconomically disadvantaged as a whole (National Poverty Center, 2012). While these disparities can find some explanation in socioeconomic factors (Sandquist & Yang, 2007; Smedly et al., 2002), segregated communities (Chan, Gaskin, Dinwiddie & McCleary, 2012; Sarrazi, Campbell & Rosenthal, 2009), lifestyle choices and distrust of the healthcare system (Armstrong et al., 2008; Armstrong, Rose, Long, McMurphy, & Shea, 2006; Cunningham, Sohler, Korin, Gao, & Anastos, 2007; Kennedy, Mathis, & Woods, 2007) there remains strong evidence that health care providers also share some of the blame (Smedley, et al, 2003; Steed, 2010; Trivedi, et al, 2011; White, Sahu, Poles & Francois, 2012). Probing the factors that lead to healthcare providers' contribution to the health disparity of black

Americans, therefore, is necessary.

Assumptions, Bias and Stereotypes

There is increasing research that examines the role of bias and differential treatment by healthcare providers within the U.S. health care system. Studies of physicians' attitudes found that many white providers perceive black patients as less intelligent, less educated, more likely to abuse drugs and alcohol, more likely to fail to comply with medical advice and more likely to lack social support (Mays, Cochran, & Barnes, 2007; Shavers & Shavers, 2006; van Ryn, 2000). Stereotyping of, or assumptions about individuals or groups different from the provider, have been found to have an influence on provider decision-making (Benkert & Peters, 2005; Brondolo, Gallo & Meyers, 2009; Green et al., 2007; Hugenberg, Bodenhausen, & McLain, 2006; Peters, 2004; Steed, 2010; White, et.al. 2012).

In *Black and Blue: The Origins and Consequences of Medical Racism* (2012), Hoberman points out that the issue of race bias on the part of medical professionals tends to be minimized within the profession even though it is obvious that it exists. However, because the harm that this bias can cause is possibly life altering, it deserves even more scrutiny and investigation to a greater degree than other professions. Hoberman contends that physicians follow traditions and views from which they came and fail to see the historical and socioeconomic issues black Americans have experienced and lack an understanding, therefore, of the perspective of black Americans based on these important factors. It may be even more profound in the case of the white physician whose "intimate involvement with medically inflicted bodies and minds may even create and intensify feelings about the racial differences they perceive" (Hoberman, 2012, p. 13). Hoberman

takes the stand that health care leaders do not wish to address the issue of racism within the health care system and that the preconceived notions about racial differences that historically plagued our health care system, continue to thrive within it still today (Hoberman, 2012).

Furthermore, studies indicate that black patients feel the effect of these assumptions made by providers and it leads to a perceived lower quality of care (Napoles-Springer, 2005; Sohler, Li & Cunningham, 2009; Utsey, Lanier, Williams, Bolden & Lee, 2006). Adegbenbo, Tomar & Logan (2006) found that individuals who sensed discrimination or bias by health care providers also reported a delay in seeking health care when it was needed (Adegbenbo et al., 2006). Jerant, Sohler, Fiscella, Franks & Franks (2011) found promising results in ameliorating health disparities through tailored interactive media computer programs (tailored IMCPs). These programs are designed to offer education to patients that will most likely reach their psychological state of awareness of the topic being focused on. The language of the IMCP is specifically written to most influence the patient based on level of self-efficacy rating. The researchers suggest a tailored ICMP that is designed by target group input and meant to address generalized group psychological states could be an effective tool in priming patients for the information to be received and lead to a more receptive audience, thus decreasing health disparities of various groups. This suggestion has not been tested, however, and remains a theory. Furthermore, it lays the burden of change on the patient and does little to address the bias the patient may feel when interacting with the health care provider. Such bias in the provider-patient interaction must be identified and addressed to ensure that all individuals receive the optimal level of care. This study will

add to the body of literature about bias and resulting disparate treatment by white health care providers in delivering (or withholding) care to the black community in Louisville from an historical perspective.

Historical writings on racial segregation in health care and changes in the system over time

At the close of the Civil War in 1865, there were nearly four million freed slaves across the southern United States. In Kentucky, a little over 225,000 slaves became free men and women (U.S. Census, 1860). Many migrated to Louisville, the state's largest city. The nation was in an uproar as to how to proceed with the inclusion of these individuals into a society that was established by and for whites. The period just after the Civil War has been called the "Reconstruction Era." This era encompasses the years of 1865-1877. During that time, a largely liberal-led U.S. government enacted laws with the intention of, among other things, addressing the civil rights of the newly freed slaves. The 13th (abolishing slavery), 14th (addressing citizenship) and 15th (allowing black men to vote) Amendments to the Constitution were all passed during this time (Foner, 1988). After this period, a transition from the liberal government to one of a more conservative, elitist bent far less sympathetic to the plight of blacks came into power. What occurred next was a long period of social segregation and disenfranchisement of blacks. The "Jim Crow" era was a period of deep divide between black and white Americans that extended from the late 1870's until the mid-20th Century and the emergence of a mass Civil Rights Movement. During this time, Jim Crow laws were enacted in many southern states to assure that the two races remained separate in most areas of daily activities (King, 1995; Woodward, 2002). Kentucky participated in these laws and practices. For example, the

Day Law, passed in 1904, ensured that black and white students would never learn in either a public or private setting together (Fosl, 2002; K'Meyer, 2009). Fosl (2002) describes Kentucky's Jim Crow laws as "patchwork" (p. 9) however, as they were implemented in one place yet not another. Jim Crow laws were systematically challenged and eventually overturned due to the dedication of the individuals involved in the Civil Rights Movement. The seeds of the Civil Rights Movement started as far back as the 1930s (Egerton, 1994) and became fully ignited by the 1960s (Dierenfield, 2004). The 1950s and 1960s brought a change in legislation that struck down the segregated policies of the Jim Crow era. For example, this era saw the passage of *Brown vs. Board of Education*, which negated the "separate but equal" assumption of Jim Crow education. For Louisville, and Kentucky, this meant the end of the Day Law and the inclusion of black students in the white educational institutions. Certainly all of these eras and events had an influence on the healthcare system of Louisville, Kentucky and served as a foundation for this study.

In addition to the general knowledge of these historical events and timeframes, extant historical literature, specific to healthcare, was used as a guide to facilitate understanding of the context of the primary source data collected in this study. Several publications exist which offered insight into the social structures and societal norms of the periods being studied, some of these specific to Louisville. Since the data collected for this study focused specifically on health or health care concerns of Louisville's black community, these histories were referenced to ascertain accurate context of the archive material as it was analyzed.

In one of his earliest publications, *Medicine and Slavery*, Savitt (1981) presents a

picture of the problems inherent in the life of the slave in the United States. Savitt describes such areas as the common style of dress, diet, housing, common illnesses and diseases, and medical treatment. He noted that clothing may have been inadequate, and shoes were the most likely contributor to health concerns of enslaved African Americans. The quality of clothing allotted to slaves would have been entirely upon the discretion of the slave-owner and varied widely. Similarly, housing was at the discretion of the slave-owner and may or may not have been adequate for the health and vigor of enslaved black Americans. Slave diets also varied by region, plantation conditions, slave-owner discretion and whether or not the slaves were allowed to plant or grow their own produce and livestock. Many times, unfortunately, their diets were not adequate to maintain optimum health. Illness was not unusual for the enslaved Americans with diseases such as respiratory illnesses, tuberculosis and gastrointestinal bacteria or parasites being most common. Medical management of slave health varied very widely among slave-owners, although many slave owners managed the health of slaves much like they would the health of their livestock. The goal would have been to optimize the slave's potential for productivity but not necessarily obtain optimum health standards. Savitt also informs us that the use of slaves and free blacks in medical experimentation was extremely common. Although Savitt describes black American slave health prior to the end of the Civil War, it lends support for this study because many of the common health problems suffered during slavery followed African Americans into that post-civil war era. Furthermore, understanding the conditions that influenced their general health upon freedom, gives background guidance to the primary source data surrounding the newly freed slave's lives in Louisville.

Historical writings which address the U.S. health care system at large, and the racism within that system were foundational to this study. Byrd and Clayton (2000) in *An American Health Dilemma*, described the evolution of Western medicine from the early influences of the ancient Greeks and Romans and explored how race and racism played in the development of medicine as a discipline and, as a result, the health care system itself. The authors demonstrated how, particularly in the southern United States, black patients were widely excluded from all white health care establishments until the Civil Rights Era of the 1960's. Byrd & Clayton described health disparities as a civil rights concern. Similar to the presented study, the authors paint a picture of the evolution of health and health care for black Americans from America's earliest history. Although Byrd & Clayton (2000) provide a clear picture of race and health care in the United States in general, it does not reveal the more intimate details of a single community, the specific stereotypes and bias that excluded the black citizens from participating in the health care system managed by whites of that community and how that system came to adjust to the current, integrated one.

In *Medicine and Slavery* (Savitt, 1978), the health conditions and care delivered to enslaved black Americans are described. Such conditions as quality of shelter, diet and treatment of illness varied from one slave owner to another. Savitt explores some of these factors and demonstrates how the enslaved black American differed, or paralleled, the health status of white Americans during the period of slavery up through emancipation. This information served as a reference in identifying the health status of the newly freed slaves coming to Louisville, Kentucky just after the Civil War. In *Race and Medicine in Nineteenth and Early Twentieth Century America* (2006), Savitt

explored the development of a separate health care system for black Americans in the south. He detailed how black Americans' health concerns were largely ignored by the white medical establishment upon freedom from slavery. Particularly in the southern United States, there were insufficient medical doctors to tend to their needs. These circumstances led to the establishment of black medical schools which in turn, perpetuated the separate health care system as black doctors strove to establish their own health care system to care for black patients. Both of Savitt's historiographies (1981 and 2006) were foundational in understanding black Americans' health needs barriers and efforts after the Civil War and through the Civil Rights Era of the 1960's. His account of the development of a separate, unequal healthcare system for black Americans served as a comparison to the data gleaned from this study. Although health care was lightly touched upon in his publications, neither of Savitt's publications delve into assumptions, biases and stereotypes about black Americans held by the white healthcare service providers which were instrumental in maintaining a segregated system. This study explicates those influences through documents and reports about this important historical period.

There are also publications that guide the understanding of black American life in Louisville. These, also, were foundational to the reported study. *Life Behind a Veil: Blacks in Louisville 1865-1930* (Wright, 1985) offers a look at the daily life of black Americans from immediate post-Civil War until the depression era. It records the primary problems in the lives of Louisville's black community and includes the community's experiences with racism, black leadership, socioeconomic hardship and educational needs. Louisville's black leaders are identified and their role in shaping the

black community delineated. Wright reported the development of black neighborhoods and the segregation of housing, employment and health care acquisition in Louisville. He illuminated the advent of the Louisville National Medical College (a medical school with a small hospital started by black physicians) and the Red Cross Hospital (also started by black physicians) as those events related to other woes that black Louisvillian's faced due to racism and segregation. Wright (1985) identified that Louisville's white community held a paternalistic view of black Louisvillians as can be seen in the following passage:

Louisville's leading white citizens often seemed genuinely concerned about Afro-Americans and generously supported a number of black causes. But these whites were very selective in choosing what to support, and in return they demanded that blacks be passive and remain in the place assigned them in Louisville society.

The paternalism exhibited by whites, just like that of slave owners, was a form of control...What existed in Louisville was racism in a polite form; it would remain polite as long as Afro-Americans willingly accepted 'their place,' which, of course, was at the bottom. (Wright, 1985, p. 4)

Having knowledge of the social, political and economic underpinnings of black Louisvillian life was critical to the focus (health care system evolution) of this study because much of the health care system evolution could be directly linked to these elements. Wright's historiography, which spanned many of the years being chronicled in the reported study (1865-1930), acted as an anchor for the investigative approach for this study.

Civil Rights in the Gateway to the South (K'Meyer, 2009) details the Civil Rights

Movement in Louisville from 1945-1980, which were also significant years reported in this study. The book provided a picture of Louisville's black community and includes further details surrounding the Interracial Hospital Movement, school segregation, housing inequities, and other social justice issues that affected Louisville's black community (K'Meyer, 2009). These events all contribute to the overall stressors which affected the community of interest and provide support for the analysis of primary source material used in this study as a reference point for understanding the collected context data and means to corroborate findings within the data.

Aubespain, Clay & Hudson, (2011) presented a history of African American life in Louisville, Kentucky in *Two Centuries of Black Louisville: A Photographic History*, which offered tremendous insight into life of African Americans residing in Louisville over the last two hundred years. It included chronological pictures and text on topics such as education, politics, and race relations that impacted the black community. These photographs and descriptions served as insight to the context of data discovered in this study and as a data collection guide to additional primary source data.

The biography of Anne Braden, *Subversive Southerner: Anne Braden and the Struggle for Racial Justice in the Cold War South* (Fosl, 2002) was similar to Wright's (1985) work and aided in providing context for the reported study. This biography gave this reader a glimpse into the life of Louisville's black community through the work of Anne Braden, a white social justice activist who worked diligently to relieve racial inequality. Ms. Braden moved to Louisville, Kentucky in the late 1940's and remained there for the rest of her life. Her involvement in addressing the plight of Louisville's black community was seminal in supporting change within this community. If there was

an issue related to racism or social injustice in the city of Louisville, she was involved in efforts to counteract it. Her biography includes one especially relevant set of events—the story of the Interracial Hospital Movement (IHM), an organization she helped form, which was instrumental in striking down segregation in emergency room services. This biography described many of the political and social dilemmas experienced by Louisville’s black community from the late 1940’s through the post-Civil Rights Movement Era, as it related to the life of Anne Braden, and thus offered corroboration for the findings within the health care system. Much of Braden’s social justice activities focused on areas such as equal housing, employment and education but with one important exception focused on the event related to healthcare issues in Louisville. This event will be described in the findings section in detail.

While the described body of literature offered a significant amount of historical data in the areas of social, economic, and political influences within the United States and Louisville, it has provided limited data regarding health and healthcare in Louisville during the period of 1865-1980’s. The described body of literature offered this investigator a solid foundation regarding pivotal events in the lives of black Americans in Louisville during the period which was the focus of the completed research. What the study in these pages explores, that had not as yet been presented in the literature, was how the healthcare system was affected by the exclusion of black citizens from Louisville’s predominately white community, the limited resources available to Louisville’s black community because of this exclusion, the attitudes and assumptions held by white healthcare providers and leaders that perpetuated the exclusion of black Louisvillians, and the motivating factors that led to the inclusion of the black community

within the predominately white healthcare system. The historical picture that emerged from this study offers a clearer understanding of how we came to our current health care system and the overall health status of black Americans in Louisville today.

Theoretical Framework

America's health care system developed as a segregated one due to the deep-seated beliefs held by the dominant white society about black people (Savitt, 2007; Smith, 1999). To understand health disparities as they relate to racism within the healthcare system requires a theoretical framework that acknowledges that racism exists. Two theories were considered as framework for this study. One, Ecosocial Theory, acknowledges racism within the fabric of the U.S. healthcare system and seeks to understand who is causing the disparate conditions within healthcare and why. This theory assumes that people absorb and reflect the social ideologies that surround them. This, in turn, leads to inequalities in health and healthcare delivery.

The tenets of the theory include “To guide both the research questions posed and the methods used, ecosocial theory posits that inequitable race relations simultaneously—and not sequentially—(1) benefit the groups who claim racial superiority at the expense of those whom they deem intrinsically inferior, (2) racialize biology to produce and justify the very categories used to demarcate racial/ethnic groups, and (3) generate inequitable living and working conditions that, via embodiment, result in the biological expression of racism—and hence racial/ethnic health inequities” (Kreuger, 2012, p. 936-937).

Utilization of this theory helped identify the influence of race and racism on health and healthcare acquisition, much of its strength was its ability to understand the

perspective of the marginalized health consumer. While this understanding was very important in health disparities research, it was not the focus area of this research and therefore Ecosocial Theory was less suitable for this study than was Critical Race Theory. Critical Race Theory (CRT) emerged in the 1970's in the field of legal scholarship. Its creation was motivated by the concern that gains in the civil rights of individuals were slowed to a near halt, and in some cases reversing. Although initially created by a few key authors who included Derrick Bell, first tenured black law professor at Harvard Law School (Douglas, 2012), and intended for use within the field of law (Delgado & Stefancic, 2006). Critical Race Theory encourages investigation of a phenomenon with a focus on the influences of race, racism and power structures on that phenomenon. Initially applied to the work of legal scholarship, CRT has been successfully utilized as a foundation for research inquiry in other fields as well. Studies using a CRT framework can be seen in the field of social studies (Daniels, 2011; Freeman, 2011), criminal justice (Bornstein, Charles, Domingo & Solis, 2012; Duran & Posadas, 2013) and most notably in the area of education research (Espino, 2012; Helig, Brown & Brown, 2012; Ladson-Billings, 1998).

According to CRT, the investigator's intent through use of CRT should be to influence change and improve social justice (Crenshaw, Gotanda, Peller, & Kendall, 1995; Delgado & Stefencic, 2001). While arguing for its use in the field of education, Ladson-Billings (1998) described it as arising from the "meaning and value imported to whiteness that CRT becomes an important tool in deconstruction, reconstruction, and construction: deconstruction of oppressive structures and discourses, reconstruction of human agency, and construction of equitable and socially just relations of power" (p. 9).

Therefore, the investigator using CRT seeks to identify the inequalities in the field of interest, appeal to the reason and humanity of others, and then identify, propose and implement mechanisms to promote equality.

Critical Race Theory consists of six basic tenets. *First*, CRT assumes that racism is pervasive in society. In fact, racism is considered an omnipresent component of American society (Carbado, 2011; Crenshaw, 2011; Delgado & Stefancic, 2012). *Second*, it assumes that racism is institutionally embedded and "advances the interest of both white elites (materially) and working-class people (physically) therefore society at large has little incentive to eradicate it" (Delgado & Stefancic, 2001, p. 102). Indeed, even in decisions that may appear to be in the best interest of black Americans, white American's interests are still paramount (Bell, 1980). In the law literature, this tenet upholds the notion that civil rights are indeed actually property rights in America (Apple, Au & Gandin, 2009). That is to say that "whiteness" is a property. That property is maintained by one of four mechanisms: right of possession, right of use and enjoyment, right of disposition and right of exclusion (Hiraldo, 2010). *Third*, CRT recognizes that race is a social construct and has no biological basis. *Fourth*, CRT asserts that minority groups are classified differently depending on the context and time of classification, sometimes called differential racialization. For example, Germans and Irish were, at one period in time, not included in the "white" group and are now identified wholly within that group. The *fifth* tenet of CRT is that of the intersectionality of categorizations. Intersectionality of categorizations refers to the ability of an individual to hold varying perspectives based on ethnic, gender and/or other differences. For example, a black female will have a different social experience with someone that differs from that of a

black male or white female. Finally, the *sixth* tenet of CRT is that because of historically different experiences, members of non-white minority groups have life experiences that differ from whites and whites are very unlikely to be aware of these (Carbado, 2011; Crenshaw, et al., 1995; Delgado & Stefencic, 2012). This tenet assumes that the collective black experience can speak to and counter the collective white experience, sometimes referred to as “counter story-telling” (Delgado & Stefencic, 2012, p.7).

Solorzano, Ceja and Yosso (2000) used CRT as the foundation for their qualitative study of racial microaggressions, or unconscious subtle racism, in the college setting. Through focus group interviews with young black students in predominately white universities, the researchers found that student experiences with perceived microaggressions occur commonly in the average black student’s college career and that these microaggressions can negatively impact the student’s performance and self-esteem. DeCuir and Dixson (2004) explored the use of CRT as a tool when analyzing the personal narratives of two black students in a predominately white, elite, private high school. This research helped to uncover the saliency of racism within the school environment in ways that may not have been detectable otherwise. For example, one of the students described a situation where a rule was made that all white apparel was to be worn at graduation. One of the participants (black female) wished to wear a traditional African headdress. In order to accommodate the rule, the student had to find an all-white head wrap (a very non-traditional African item) for the occasion after school officials denied her request to wear a traditional African headdress. The authors note that this, being denied the right to wear her cultural garb, related to the CRT tenet of interest convergence or the notion of whiteness as property. The property of whiteness, in this

situation, is the graduation ceremony and the customs that the white institution has deemed fitting for participating in the ceremony (right of disposition). The school official's refusal to allow the black student to wear traditional African style headdress was the exercising of the white property owner's right to exclusion (DeCuir & Dixson, 2004; Hiraldo, 2010).

The last CRT tenet most closely reflects the healthcare experience of black patients which has differed historically from that of white patients. Furthermore, white healthcare providers are largely unaware of differences in life experiences. In a broader understanding of CRT, the theory challenges the basic assumptions of power and knowledge as seen from white society's perspective and offers a counterintuitive, black experience from which to view a topic. In the case of the evolution of healthcare for black Americans, the process of integration may be very different from the black American perspective as compared to those of a white healthcare provider.

A literature review was conducted using "Critical Race Theory" as keyword in the Ovid Medline database to identify the prevalence of the theory in health care literature. Fourteen articles, from the years 2002-2012, were retrieved. Of those fourteen, only eight had significance to the health care field. Of those eight, only two were the products of research projects, the others were papers arguing for the value of CRT in health care sciences. The two healthcare research articles will be discussed.

In their study, Ford and Collins (2010) used CRT to guide their research on HIV testing and prevention by black men. Because black men have higher rates of HIV and AIDS than do white men, were often diagnosed at a later stage of illness and had a poorer prognosis, a common assumption may be that they did not practice preventive methods.

These researchers were interested in the difference in HIV test seeking behaviors between white men and black men. They used CRT as the theoretical framework for this study. They cited four core areas (based on the six CRT tenets) of CRT to conduct their study: race consciousness-all of the researchers made written note of their own internal feelings about black men. Contemporary orientation- the researchers noted that in current American society, racism is subtle and less conspicuous than historically was the case. Nonetheless, in keeping with the six tenets of CRT, they recognized its presence and actively sought to identify it. Center in the margins- this required the researchers to recognize that normal states of being experienced by the majority (white) population were not necessarily the same for marginalized individuals (black) and necessary steps were made by the researchers to position themselves as outsiders looking in. Conscious effort was made to understand the central issue (HIV testing and prevention) from the marginalized point of view. Finally, the researchers identified what they labeled as “praxis,” which involved constant evaluation of what they were discovering as it related to the black perspective. These researchers made the assumption, based on CRT, that the perspective of the black participant was different than the white participant so their goal was to keep the focus strictly on the black perspective. They employed black researchers to conduct interviews and gather data. In addition, staff read literature about race and racism to keep with the intention of limiting biases stemming from class or gender, even though they shared the same racial background as the participants. The findings of this study revealed that black men were actively engaged in seeking testing for HIV as well as practicing prevention. Without using the CRT framework, the researchers realized that these findings may have been illusive because the findings would have been based on

white men's values, instead of values shaped within the social context of the black community (Ford & Collins, 2010).

In their study of African and Caribbean black gay and bisexual men in Canada, George et al., (2012) used CRT as the theoretical underpinning of their community based research project to understand the behaviors of black gay or bisexual men. They conducted both surveys and used in-depth interviews to obtain data. The primary tenet of CRT applied in this study was the final tenet that assumes the black perspective is different from the white perspective. By engaging individuals from the black community in interviews, the authors utilized "counter story-telling" (Delgado & Stefencic, 2012, p.7). Their findings suggest that gay and bisexual black men undergo social and cultural challenges that are unique to their situation, that they have a sense of not belonging to either the black community or to the gay community due to the intersectionality of their situation, but that they were resilient in finding a way to socialize with peers of both groups (George et al., 2012).

In conclusion, the findings in the literature reveal a higher burden of disease and among black Americans compared to white Americans. In addition, black Americans are more likely to suffer greater socioeconomic woes which impact that burden of disease negatively. Research on health disparities describes a difference in care delivery across the medical spectrum. To compound this issue, some research suggests that white healthcare providers carry assumptions or biases which hinder their ability to deliver the same quality of care to black patients. There is a paucity of research connecting the racism of the segregated era to the current health disparity problem. Using a Critical Race Theory framework, a problem can be seen from the eyes of the black individual as

opposed to the white individual perception. Findings from this study will help to bridge the gap between the segregated healthcare history and the current health disparity by utilizing this CRT framework to study one southern city of the U.S.

CHAPTER 3: RESEARCH METHODOLOGY

An historical sociological research approach was used. To clearly understand historical sociological research, an understanding of historical methods will first be discussed. This will be followed by a discussion of historical sociology, which is a unique method of historical study.

Historical research is the search for reliable sources and the interpretation and compilation of those sources in a way that tells a story about a particular event or occurrence in history. The goal of the historian is to “bring the past back to life by re-thinking past thoughts in the present” (Trachtenberg, 2006, p. 8).

Jupp (2006) describes the method this way:

A method that seeks to make sense of the past through the disciplined and systematic analysis of the ‘traces’ it leaves behind. Such traces may be of many different kinds, ranging from everyday ephemera, artifacts and visual images, to old buildings, archeological sites or entire landscapes. The most widely used historical traces, however, are written documents, whether of public or private origin. (p.134-135)

Historical research is unique from the majority of social science research methods in that the ability to assume exactly how one will carry it out is nearly impossible, as one cannot foresee what will develop from the data as it is collected. Nonetheless, there are some basic tenets to this form of research to ensure that the researcher follows scientific rigor

and meets the expectations of scholarly work. The first of these basic tenets is to identify the topic and begin to identify source material to collect as data.

To reconstruct the past, the historian searches through source material to see the studied topic from the eyes of the individual(s) who lived it (Tosh, 2010; Trachtenberg, 2006; Westhoff, 2012). The researcher uses a unique dialogical reading and analysis of the source material known as historiographical thinking (Fallace & Neem, 2005) or historiographical mapping (Westhoff, 2012). Source material can be a relic (such as part of a building structure) or a testimony about the event being studied. Testimony may be either spoken, as in the case of oral histories, or it may be written documents that exist from the period of the event being studied. The historian guides the research process by comparing source materials to build or construct the story as it unfolds (Johnson & Christensen, 2012; Howell & Prevenier, 2001).

A source may be either *primary* or *secondary* in nature. Primary source data, documents that were written at the time of the event being studied, are the most preferable. As one gets further from firsthand information, the less reliable it becomes (Ross, 2004). A primary source is a document that either directly or indirectly gives the researcher information about the topic being studied. An example of a direct primary source is a hospital business plan written in 1952. It gives firsthand evidence of the decisions white healthcare providers and administrators made regarding the admission of black patients. A hospital census book from the early 1900's would be an *indirect* primary source. It gives the researcher an image of what hospital admission policies might have been like. However, since other factors may have affected the admission of the black patients during the logged period, it is only an indicator to the possible

admission practices.

Secondary sources are written documents by others which give insight into the topic the investigator is studying. These can be excellent sources for identifying the context of the source material that the researcher is analyzing (Johnson & Christensen, 2012).

The researcher utilized these sources, especially primary sources, in creating a story about the past (Howell & Prevenier, 2007; Johnson & Christensen, 2012). The resulting story using the source material may be written as descriptive or interpretive narrative or a combination of both (Tosh, 2010). A descriptive writing simply tells the story based on the source data, a sort of narrative account of the material. Whereas the interpretive writing seeks to find the meaning in what was found and formulate assumptions that can be inferred from these data. The second, interpretive writing is often used in historical sociological research writing.

Historical sociological research is the melding of traditional sociological methodology with historical methodology. Essentially, historical sociology is the study of human behaviors responsible for forming the structures of a society during a period of time in history (Dean, 1994). This research approach is always conducted with a theory or conceptual model as a guide in collecting and analyzing data (Skocpol, 1984). According to Shaw (2000), historical sociology draws on “historical perspectives centered on a comparative sociology of world civilizations” (p. 232). Historical social researchers are interested in tracing a particular issue back to its origin. Mahoney (2000) calls this “path dependence” and describes the historical sociological methods process this way:

Path dependence characterizes those historical sequences in which contingent events set into motion institutional patterns and event chains that have deterministic properties. The identification of path dependence therefore involves both tracing a given outcome back to a particular set of historical events, and showing how these events are themselves contingent occurrences that cannot be explained on the basis of prior historical conditions. Because the presence or absence of contingency cannot be established independent of theory, the specification of path dependency is always theory-laden. (p. 507)

Mahoney states that each step in the chain of events is dependent on previous steps with the end result being the outcome of which the researcher is investigating.

The end result, or topic of investigation, of this study was health disparities and the role of healthcare provider's in this phenomenon. Using the historical sociological method of inquiry was ideal, as the investigator sought to understand the "path dependence" of unequal care delivery within the healthcare system.

Methods

Setting

All data that were collected for this study were obtained within Louisville, Kentucky. Archival materials, in the forms of records, reports, letters, newspaper clippings, photographs and other documents, were gathered from the University of Louisville, University Archives Collection (UARC) and the University of Louisville, Kornhauser Library History Collection (KLHC) departments. Additional archive documents, including business documents, photos and reports, were obtained from the

Norton Hospital Library Archive Collection. Oral histories were collected from study participants in their homes or offices. In addition to these sources, secondary source materials, which related to the history of the healthcare system, race in healthcare or history specific to Louisville's black community, were also used.

Sample

To identify pertinent archival material to be included in this study, the investigator consulted the KLHC department head, Katherine Johnson. She was able to identify several archival collections that held material of relevance to the study phenomenon. A snowball effect occurred as primary source material often led to the investigation of other collections. In addition to the material at KLHC, Johnson directed the investigator to collections within the UARC. City municipal reports and records of the Waverly Hills Tuberculosis Hospital, Red Cross Hospital, University of Louisville School of Medicine Anatomy lab, as well as other pertinent papers or written information relevant to the study were identified by archivist Tom Owens of the UARC.

In conducting oral history interviews, the initial oral history participant was identified through research conducted at Norton Hospital Library. That participant recommended several white physician participants and one white nurse participant. Word of mouth through the University of Louisville, School of Nursing (especially through Vicki Hines-Martin PhD, RN, FAAN and Alona Pack MSN, RN), resulted in the identification of several black nurse participants and these participants in turn identified others. One black physician was identified through a personal contact and one black physician was identified through direct recruitment by calling the Park DuValle Health Center. A total of 12 oral history participants were included in the study.

Data Sources

Primary source data were retrieved from the following collections at the KLHC:

Table 1 University of Louisville, Kornhauser Library History Collections (KLHC)

| Collection | Years Covered |
|--|-----------------------------|
| Children's Hospital, Record Group 211. | 1955-1962 |
| Jefferson County Health Department, Record Group 152. | 1936-1940 |
| Louisville Community Chest Health Council, Record Group 180. | 1925-1961 (bulk 1925-1939) |
| Louisville General Hospital School of Nursing, Record Group 117. | 1889-1996 |
| Louisville Health Department, Record Group 153. | 1900-1942 |
| Louisville-Jefferson County Health Department, Record Group 154. | 1942-1979 |
| Louisville National Medical College, Record Group 204. | 1889-1908 |
| Rowntree, Grady R., M.D. Papers, Record Group 279. | 1872-1992 |
| University Hospital Records, a.k.a. Louisville General Hospital; Louisville City Hospital, Record Group 162. | 1886-1983, |
| Workers Progress Administration Research Materials, Record Group 127 | 1937-1940 |

In addition, primary source data was retrieved from the following collections housed at the University of Louisville, Ekstrom Library, University Archives and Records Collection (UARC):

Table 2 University of Louisville, University Archives and Records Collection (UARC)

| Collection | Years |
|---|---------------------------|
| City of Louisville municipal reports, 1866-1916 | 1866-1916 |
| Community (Red Cross) Hospital records, 1907-1976. | 1907-1976 |
| Lyons Papers. | 1930s-1940s |
| University Records, Medical School Anatomy Lab file. | 1880s-current |
| Waverly Hills File | Approximately 1910-1960 |
| African American Oral History Collection. | Approximately 1920s-1980s |

In addition to the University of Louisville sources, some primary source data was collected at the Norton Hospital Library in Louisville, Kentucky. These data were in the form of photographs and business documents spanning from approximately early 1930s through the 1980s.

In addition to these, more primary source data were collected from the personal collection of Ms. Flora Ponder (black, public health nurse), which included obituaries of public health nurses in Louisville, artifacts from the collection of Ms. Laura Dooley (black, public health nurse) and a scrapbook about the Park DuValle Health Center, ca. 1970s. Interlibrary loan services were utilized to receive microfilm reels from the

National Archives containing Freedman’s Bureau Records pertaining to the hospital and dispensaries established by the Bureau in 1867 established in Louisville, Kentucky.

Oral history participants were identified through the snowball approach. This approach starts with identifying one or two participants who then refer others from their network. The result is that each participant may lead to several subsequent participants much like a snowball gathers more snow as it rolls down a hill (Denzin & Lincoln, 2007).

Active recruitment of participants with the following inclusion criteria ensued: 1) the individual had some experience with the health care system in Louisville, Kentucky during the studied time period and 2) was willing to have their oral history account recorded and housed at the University of Louisville Oral History Center. Oral histories were obtained from the following:

Table 3 Oral History Participants

| Oral History Participant | Healthcare Profession | Knowledge of what years? | Race |
|---------------------------------|---|---------------------------------|-------------|
| Wade Mountz | Norton Memorial Infirmary President | Late 1940’s through current. | White |
| Dr. Milton C. Young, III | First black medical resident at University of Louisville, School of Medicine. | 1961-current | Black |
| Dr. Leonard Goddy | University of Louisville Medical School graduate and Orthopedic Surgeon | 1950-current | White |
| Dr. Wayne Kotcamp | University of Louisville Medical School graduate and Orthopedic Surgeon | 1950-current | White |

| | | | |
|--------------------|---|---------------------|-------|
| Dr. John Howard | Pediatrician, Park DuValle Family Health Center | 1969-current | Black |
| Thelma Jackson | Registered Nurse, graduate of Nazereth School of Nursing (Spaulding University) | 1950-current | Black |
| Shirley Powers | Registered Nurse, graduate of Norton Memorial Infirmary School of Nursing | Mid-1950's-current | White |
| Flora Ponders | Registered Nurse, graduate of Louisville General Hospital, School of Nursing | Late 1940's-current | Black |
| Norma Mason-Stykes | Registered Nurse, Hanover College Indiana | 1930's-current | Black |
| Alma Wilson | Registered Nurse, graduate of Louisville General Hospital School of Nursing | 1958-current | Black |
| Jessie Howard | Licensed Practical Nurse, graduate of Central State Hospital Nursing Program | 1958-current | Black |
| Mary Malone | Registered Nurse, Jefferson Community Technical College | Late 1960's-current | Black |

An interview guide was developed for the study. An introductory paragraph which prefaced the seven item questionnaire described the scope and focus of the study. The first two questions obtained demographic data on participants' age and place of origin, as well as education and employment history. The remaining five open-ended

questions asked the participant to recount his/her recollection of the health care environment in which he/she worked in relation to black patients to prompt the participant's recollection of events surrounding segregated care, and the transition to integrated care. The interview guide was developed for the study to elicit as much data from the participant as possible, have the majority of the narrative come from the participant's own recollection with the least amount of probing from the investigator (Seidman, 1998). The interview guide was reviewed for content appropriateness and comprehensibility by an expert in qualitative interviewing and is attached as Appendix A.

Procedure

Ethical Considerations /Confidentiality & Protection of Human Subjects.

Study approval (12.0357) was obtained prior to the start of this study from the University of Louisville Institutional Review Board. In addition, approval was received from the research committees of Norton Hospital, and Jewish Hospital.

Because the study included oral histories of living individuals, written informed consent was obtained. A consent form was adopted from the University of Louisville Oral History Center and approved by the University of Louisville Human Studies Committee (see Appendix B). Information about the study was provided by phone. Each potential volunteer was provided information about the study and provided the opportunity to ask questions prior to obtaining written informed consent. The procedure was explained including the investigator's intent to audio record each interview and to house the recordings, upon completion of this study, with the University of Louisville

Oral History Center. If the potential volunteer consented to an in-person meeting, an appointment was made to meet the participant in a place designated by them (all but two meetings took place in the volunteers' own homes, one in an office and one in a hospital cafeteria). Upon meeting, the consent form was reviewed with the volunteer and time allowed to ask questions. No volunteers declined to participate in the study.

Data Collection

Finding suitable sources may be the most challenging aspect of historical research. Many historians have noted that for every piece of the story found, more questions are generated. Historical research is similar to the grounded theory method of research in that one's findings guide subsequent searches (Denzin & Lincoln, 2005; Johnson & Christensen, 2012).

Oral History Data

Recruitment was conducted by word of mouth and active recruitment (in the case of the physician at Park DuValle Health Center) and then continued from snowball effect as participants recommended other potential participants. Potential participants received a prepared letter, introducing the researcher and the study topic (Attachment C) or were called by the researcher and similarly informed. Appointments were set by phone and consent was obtained on the day of interview prior to the interview start.

Interviews were digitally recorded onto an Olympus Digital Voice Recorder and then stored on the investigator's computer hard drive as well as an external memory device. Informed consents and recorded data were kept in a file in the possession of the investigator during the study period. Notes were taken during the interview and that notebook kept in the possession of the investigator.

Archival Data

The collection of archive material was conducted by reviewing each item in the collections previously identified. Items identified as pertaining to the research questions were photocopied, labeled and kept in folders based on data category. Notes were made in the investigator's methodological notebook which included thoughts for further exploration, as well as hypotheses by the investigator about the content of the items collected. For instance, when a letter in the Community Chest Council was identified to reflect the care and health of Louisville's black community, and the letter named an article that was to have been attached, but wasn't, a note was made in the notebook of the citation as recorded on the letter along with a prompt to search for the article from on-line sources. Later, when reviewing these notes, the cited article was located and retrieved by using the Interlibrary Loan services of the University of Louisville Library. Microfilm data were also printed, in some cases, and notes made to record their content.

Data Analysis

Oral Histories

Interviews were conducted and recorded with a digital recorder. The analysis of oral histories was performed using manual sorting and coding methods (Howell & Prevenier, 2007). Initial coding began during the interview through extensive note-taking and marking of key statements or categories for quick recall. Once interviews were completed, audiotapes were listened to and reviewed repetitively as other interviews were completed for an iterative process. Key statements were transcribed, and then organized according to categories then themes and anchored to particular occurrences in history to which they were associated.

Archival Data

Collection of primary source data was simultaneous with analysis of the data. As the analyzed sources began to paint a picture of the past, the very picture being painted guided the search for more sources. According to Trachtenberg (2006), the historian should “actively” analyze the data by “thinking” and generating more questions.

In addition to identifying and collecting primary source data, the investigator analyzed the data for authenticity and accuracy. This process required corroboration, sourcing, and contextualizing. To corroborate data, the researcher compared the document to other documents (including secondary sources) for consistency in content according to Johnson & Christensen (2012). To assess authenticity and accuracy, the investigator used a “sourcing” method. Sourcing is the process of identifying the author of a particular document, as well as the date and place in which it was created (Johnson & Christensen, 2012). Secondary source material was particularly helpful in this area as often a document could be compared to written accounts of individuals or organizations which gave credence to the primary source material’s authenticity.

Another method used to assure authenticity of primary source documents was “contextualizing” Contextualizing is the process of identifying the time of the writing and the surrounding events that may have influenced its production (Johnson & Christensen, 2012). Again, secondary source material was very useful in identifying the context of much of the primary data collected.

Garraghan and Delanglez (1946) posited that the historian’s goal is to gather as much evidence as possible with the majority of that evidence leading to the same conclusion. With the majority of evidence pointing to one conclusion, the conclusion

must be the most correct one. They called this the “principal of sufficient reason” (Garraghan & Delanglez, 1946). This study was constricted by time factors, but the investigator reached a level of saturation which met the principal of sufficient reason before finalizing data collection.

The data was catalogued chronologically for quick retrieval. Folders were compiled and primary source material grouped by decades. Within each folder, materials were labeled individually with specific indicators relating to assumptions by whites. This process is important for assessing the social underpinnings of the events as they happened (Dean, 1994). For example, several pieces of archival material were relevant to bath houses; these were labeled “bath houses”. Emerging categories that demonstrated white health care provider’s assumptions about black patients became apparent early in the collection process. These categories, when identified on source material, were flagged with the appropriate topic and stored in decade folders. Over the course of the analysis, these categories which are chronicled as they appeared in the data were merged into themes and then identified by themes in discussion. Finally, two prevailing themes related to white health care providers perceptions could be seen through data analysis and were identified by the investigator as a period of *Paternalistic Apatheia* and a period of *Paternalistic Opportunism*. The following findings about the attitudes of white health care providers are organized in such a way as to illuminate these two themes and their relation to the political, social and economic changes, but most importantly, the events within the healthcare system in Louisville.

CHAPTER 4: FINDINGS

Introduction

This chapter will reveal the findings of this research study in four parts. Initially, a chronological format will be used to paint a picture of the major trends and concerns for the health and health care of Louisville's black community. This chronology will be arranged based on findings for general eras. The primary data is presented according to the era in which it was found. Because data reflecting a particular era may have been more plentiful for some eras than others, these eras are not presented equally in volume of content. They are merely presented to reflect the data that was extracted. Furthermore, while collecting and analyzing data, two overarching themes emerged. Therefore, the chronology is split into two larger timeframes, reflecting these themes. The themes, paternalistic apatheia and paternalistic opportunism will be discussed first. Then presentation of findings will follow.

Paternalistic Apatheia/Paternalistic Opportunism

Analysis of the data revealed two sequential themes regarding white health care provider's attitudes toward black Americans in Louisville throughout the decades prior to and subsequent to the Civil Rights Act. During the post-Civil War period and through the late 1940's these attitudes could best be characterized as obligatory, *Paternalistic Apatheia* and *Paternalistic Opportunism*. Paternalism is characterized as "a system under which an authority undertakes to supply the needs or regulate conduct of those under its control in matters affecting them as individuals as well as in their relations to authority

and to each other” (Miriam-Webster Dictionary, 2013). Wright (1985) noted “from antebellum days, when most of the slaves had worked in close contact with their masters and mistresses, a form of paternalism had developed...the paternalism exhibited by Louisville whites, just like that of slave owners, was a form of control” (p. 2). In addition to a paternalistic attitude, white healthcare providers also appeared to be apathetic to the needs of Louisville’s black community. Religious philosophers of the late Antiquity period referred to the word “apatheia” to denote lack of passion, stillness, immovability in a religious sense (Rasmussen, 2005). Miriam-Webster Dictionary defines apatheia as “freedom or release of emotion or excitement” (Miriam-Webster Dictionary Online, 2013). This definition is a befitting characterization of the attitudes of white healthcare providers of the period prior to desegregation. They appeared to be unmoved emotionally by the often dire state of healthcare for Louisville’s black community. They, tended to take the health of Louisville’s black community into concern only insofar as it affected the white community. Outside of self-interest, or occasionally obligation, the white health care providers appeared to have little concern for the healthcare needs of the black community of Louisville. It is for this reason that the entire timeframe was labeled “paternalistic apatheia”.

After the desegregation of the health care system, the attitudes of white health care providers can be described as paternal opportunism. There continued to be an attitude of paternalism seen, but the healthcare providers no longer seemed completely apathetic toward black patients. During this time, white providers began a gradual practice of including black patients when it was prudent to the white healthcare provider to do so. This inclusion of black patients due to the self-interest of the white healthcare

provider exhibits a form of opportunism. While it is not clear how much the burgeoning Civil Rights Movement had to do with this change of events, it is clear from the evidence that the initial inclusion of black patients within the previously segregated white healthcare system in Louisville was indeed a result of the self-interest of white physicians. Opportunism is the practice of taking advantage of opportunities for self-gain (Miriam-Webster Dictionary Online, 2013). Although often associated with individuals who are knowingly taking advantage of opportunities with no regard to the consequences, an opportunist may not always be aware that he is doing so (Silverman, 2004). In some instances the individual may not realize the motivation behind his decision. Nonetheless, even when we make decisions unwittingly purely out of self-interest, it is a form of opportunism. Therefore, the timeframe covering desegregation and after is labeled the period of paternalistic opportunism. Part one of this chapter will address the era of paternal apatheia and part two will address the era of paternal opportunism.

Part three will present the documented assumptions and attitudes by white health care providers and officials towards black Louisvillians. Part four of this section will present the factors that motivated the white health care providers to integrate Louisville's health care system. Finally, part five will discuss findings that give insight to the quality of care delivered to black patients before and after the integration of the health care system.

Part I

Paternalistic Apatheia

What health care was available to black Americans from 1865 until integration?

Immediate Post-Civil War (1865-1866)

Just after the Civil War, the United States began an era of change referred to as the Reconstruction Era. During this period of change, laws were enacted to address the civil rights of the newly freed slaves. One example is the 13th Amendment to the U.S. Constitution, which made slavery illegal, followed by the 14th and 15th Amendments making black people U.S. citizens and giving black men the right to vote (Foner, 1988). The Freedmen's Bureau was established as a branch of the U.S. military and was tasked with keeping order, and seeing to the well-being of the freedmen and women. Violence against the newly freed men and women was common place. Wright (1990) noted that the largest violence against Kentucky's black population occurred just after the Civil War and that by the 1870's had become commonplace. When the Civil War ended in May of 1865, the city of Louisville braced for an influx of new residents. Already filled to the brim due to Union soldier presence within the city, the arrival of newly freed slaves began to add to the population. All across the south, the newly freed slaves began to migrate to locations where they could find work. Some chose to stay and were offered "employment" by their former owners but many sought a new approach to life and work. Cities like Louisville saw an increase in population, especially of black citizens during the days following the end of the war and slavery. Even before the war had yet ended, Louisville began to see an increase in the population of black citizens of nearly two

hundred individuals per week. In the ten year period between 1860-1870 the black population in Louisville ballooned 120 percent (Wright, 1985). Certainly, this sort of large increase in population impacted the health and well-being of the city's residents.

Black individuals looking for work in the city primarily found employment in low-wage service industry jobs, largely domestic in type. They also found themselves shunned socially. While they were more likely to have lived amongst whites during slavery, after slavery they were more likely to be grouped together away from whites and the chasm between the two races deepened (Aubespain, Clay and Hudson, 2011). Subsequently, and due to the financial and social tide of the times, blacks found themselves in want of adequate housing. A Works Progress Administration (W.P.A.) document of the Louisville Health Department tells of the "accumulation of negroes in badly constructed huts" living on the site of the old military prison on Broadway between Tenth and Eleventh Streets (WPA 12-2, August 15, 1866). In his message to the city in 1866, then mayor Phillip Tomppert addressed problems the city must face with housing the newly freedmen and recommends that the Board of Health go to work with the military in handling the problem. He states, "For unless they are prevented, they (freedmen) will crowd in numbers of from ten to twenty in one room, and when the warm weather begins it cannot help but brood disease" (Louisville Municipal Reports, 1866, UARC).

The burden of an ever increasing population weighed heavy on the health officials in another area as well. The issue of sanitation for such overcrowded housing was a very real issue of the time-period. Infectious disease was an ever present threat and the city recognized that it needed to address sanitary matters in order to ensure the health of all

Louisville citizens. The *Report to the Board of Health* found in the WPA files emphasizes the concerns that come with such a large increase in population:

The belief that our city population will increase hereafter much more rapidly than at the former period in its history, is based upon the recent change in the labor system of the state...The system of free labor, in what we have styled free States, as distinguished from the slave States, has had the reversed tendency or effect, and hence we find that their people are congregated to a large extent in cities....And if this large proportion of the city to the rural populations should obtain in our system of labor we shall soon find our city growing rapidly into a great central metropolis. Hence the importance at this particular time of having the people so instructed in the great principles of sanitary science so as to enable them to so regulate and direct the future growth of the city as to avoid the grave and almost irremediable errors or mistakes of the past, and which, if continued in the future, will certainly be followed by the penalties of forfeited health, premature death, orphanage, pauperism and crime. (WPA 12-1, 1866)

The city's leaders expected a large influx of citizens into the city and they expected those individuals to be black, newly freed slaves. They also had the foresight to plan for an increased burden of disease if a sanitation modicum was not addressed. It is not clear if their concern was for the welfare of the black residents whose influx they expected or for their own, however.

The rapid increase of the population of Louisville just after the Civil War created a very real dilemma of sanitation. In September of 1865 it established the Board of Health "for the purpose of improving the sanitary condition of the city of Louisville"

(WPA files 12-2, 1866). The city feared that the build-up of waste matter would lead to an epidemic of cholera such as the city had experienced in 1850. The leaders were well aware that “hidden filth, imperfect ventilation, deficient sunlight” as well as “lodging apartments too much crowded” were dangers that had to be moderated (WPA 11-104, 1865). To manage the problem, the sanitation commission appointed “Sanitary Inspectors” to examine the dwellings within appointed districts. The inspectors were to examine dwellings, buildings, cellars and privies to make sure that waste build-up was not a hazard. Any building or privy deemed to be “foul, damp or otherwise prejudicial to health” would be reported and notice given to the occupants that the filth was to be removed. If the occupant failed to do so, or was unable to do so, it would be handled by the Board of Health at a cost to the occupant. In addition, night carts were used to carry waste out of the city proper. This service was not a public service but a private one, and quickly became somewhat of a monopoly. Initially, only one company existed in the city with which to do this work and that company only had three carts; far insufficient for removing the waste of all the city’s neighborhoods. That company charged \$12 per load (25 bushels) a significant sum of money in these times. Eventually, three other companies opened at the urging of the Board of Health. Soon, there were eight to ten carts utilized to remove the waste from the city. The price of waste removal per bushel dropped to a range of \$6-\$8 (WPA 12-2, 1866). These expenses and the penalties for not complying must have been a concern for the freedmen living in Louisville, as they were more likely to be subjected to the poor, overcrowded conditions described above. However, no documentation was found that demonstrated the extent of hardship, if any, this ordinance created for the black community.

Overcrowding did cause a hardship to the freedmen, however, and although the city officials had rules regulating occupancy of housing and conditions, it appears they often overlooked these out of need for the predicament of the black citizens. The following excerpt from a WPA (1866) document of the board of health gives an example:

Dr. Bell said that great complaint had been made for some time by citizens in the vicinity of the old military grounds, corner of Tenth and Broadway, on account of its occupancy by Negro families, fear was entertained that the congregation of these Negroes would cause a pestilence in the neighborhood. At the request of the Health Officer he, (Dr. Bell) had visited and examined the place, and could see no reason for apprehension on the part of the citizens. Nobody stood in peril but the occupants of the shanties themselves, and so far there had been no sickness of any consequence among them. He thought it would be wrong to have the negroes removed, as they might and probably would fail to obtain as good accommodations elsewhere in the city. In view of this case, he would introduce the following resolution, which was carried. Whereas, Complaint is made of the tenements stretching across the ground formerly occupied by the Military Prison on Broadway, and it is evident there is nothing in the character of the locality likely to spread disease North, South, East or West of the grounds, and the tenements can scarcely be removed to better quarters; therefore Resolved, that the Health Officer have it inspected from day to day, and have it kept as clean as circumstances will permit. (WPA 12-2 1866)

While community leaders took into consideration the fact that these residents would

likely have nowhere else to go, it is interesting that they point out that these black residents are only a menace to themselves.

Small pox appeared to be a significant threat to the city just after the Civil War. A Louisville Daily Courier (January 4, 1866) noted the “alarming prevalence of smallpox among the negro residents in Louisville. The article sited the crowded “dingy rooms, cellars and even outhouses” that these individuals were living in as a reason for high prevalence of disease. In an 1868 report, the city health officer states “I have supplied the dispensaries of the city with vaccine matter and had notice given to the colored population (among whom this disease is confined) that they would be vaccinated at any of the dispensaries (Louisville Municipal Reports, 1868, UARC). An 1869 report of the cases of small pox being treated for the year are 7 whites and 19 black it would be some time yet before this disease would be completely eradicated from the city.

Freedmen’s Bureau Steps In 1865-1868

In addition to overcrowding and poor sanitation, the black citizens of Louisville also suffered frequent abuse and ill-treatment by the white citizens during this time. In “Louisville and the Civil War”, author Bryan Bush states that the soldiers living in the city, as well as white citizens, would take out their frustrations on the black population. Although no deaths were reported, many beatings were. In addition, injustices against the freed people occurred regularly by the white community (Bush, 2008). It was so much the case that Louisville found itself hosting the Freedmen’s Bureau in June of 1866. According to Aubespain, Clay and Hudson (2011), “there was sufficient racial violence and social turmoil to warrant placing Kentucky under the jurisdiction of the Bureau of Refugees, Freedmen and Abandoned Lands...making Kentucky the only non-

confederate state to earn that dubious distinction” (p. 75).

The Freedmen’s Bureau was a federally established department, run by the military, that sought to assist the newly freed slaves to transition into their new lives. The Bureau did this by supervising labor contracts, intervening with matters of dispute between the freed men and white individuals, aiding in establishing schools and legalizing marriages. Creating a just climate was the expectation and the Bureau’s officers kept written report of “outrages” inflicted on freedmen in Kentucky and Tennessee. A few entries demonstrate the climate in Louisville:

February 15, 1868- A little girl, aged nine years, was, on the 17th day of January, brought to the freedmen’s hospital by a man named Bull. Upon examination it was found that her hands and feet were frozen dreadfully. Her back was scarred all over, the stripes having probably been inflicted with cowhide. Upon investigation it was ascertained that the whipping was done by the wife of Mr. Bull and the child was frozen by being compelled by Mrs. Bull to sleep in the coal-house. All of the child’s toes were amputated. This happened in the law-abiding city of Louisville. (Freedmen’s Bureau, 1868, National Archives and Records)

The “Sick and Wounded Freedmen Report” describes a freedman with a gunshot wound to the left side of the abdomen and back “inflicted on a discharged colored soldier he says, by a white man who without provocation attacked and stabbed him in these parts with a pocket knife in Louisville, Kentucky on the 6th.” Sometimes the wounds were the result of interaction with other freedmen as was the case in the report of a fellow with a gunshot wound of his left leg resulting from, “the accidental discharge of a revolver in

the hands of a freedmen, wound not serious” (Freedmen’s Bureau Reports, 1866, National Archives and Records).

In Louisville, a hospital was set up to care for the sick or injured freedmen by the Freedmen’s Bureau. Subsequently, dispensaries were also established to address illnesses and dispense medications. A thorough investigation into seven reels of Freedmen’s Bureau Records (those pertaining to the health care of Louisville) of the Freedmen’s Bureau Records housed at the National Archives and Records Administration revealed a glimpse into the state of health and health needs of Louisville’s black population just after the Civil War.

In June 1866, the U.S. General Hospital for Refugees and Freedmen opened in the former Crittenden Army Barracks. The records show an admission of fifty-one patients. One man and two women died during that week of June 23-30th and sixty beds were unoccupied. This appears to have been the opening week of this facility. On July 28, 1866, within one month of opening, the census was eighty-one patients and twenty-four beds were vacant. These numbers steadily increased and, by August 18th, 1866, the hospital had a census of one hundred patients with eight beds listed as vacant. Within approximately seven weeks of opening, the hospital had nearly filled to capacity. These numbers reveal that the hospital was a much needed service to the black community during this time.

In addition to the hospital, the Freedmen’s Bureau established a dispensary within the city of Louisville on August 9th, 1866. The army appointed a Swedish born physician, Dr. John Ouchterloney who arrived in America in 1857 and earned a medical degree from the University of New York in 1861. A Union Army medical officer since

1862, Dr. Ouchterloney had helped to establish the various Union hospitals in the city during the war (Hynes, 1938). The first data entry for this dispensary states that six males (two children) and eleven females were served that week. By December 15th, 1866, those numbers had risen to thirty-three men, eighteen women, eleven boys and five girls. As the year closed, a total of nearly 170 freedmen were being treated by the Freedmen's Bureau.

In 1867, number of freedman and women in the U.S. General Hospital for Refugees and Freedmen began to increase again. It is not clear how the hospital was able to increase bed capacity but the report of treated patients remaining within the hospital on a weekly basis spiked to 168 by February 2nd. It rose again in April of that year to 184 and continued in that range throughout much of the year. By December it had spiked again to 213 patients. Meanwhile, the dispensary began to see a rise in patient load as well. The total number of patients treated at the dispensary in February of 1867 was 71. By March it was up to 99 patients and a second dispensary was opened to aid in the work. The second dispensary saw seven patients in its first week of operation. However, by May it was also treating in excess of thirty patients per week. By the end of 1867, 211 patients were being treated at the hospital, 113 at the first dispensary and 86 at the second.

In 1868, the Freedmen's Bureau continued to run the U.S. General Hospital for Refugees and Freedmen and the dispensaries. On January 8th it reported 245 patients in the hospital, 126 in the first dispensary and 104 in the second. Similar numbers appear through the first six months of 1868. As the only apparent location for black citizens to seek medical care, the Freedmen's Bureau facilities were thriving.

It is possible to ascertain a little about the quality and conditions of the hospital and dispensaries from these archival documents. For instance, when the hospital opened in late June of 1866, it had a census of 48 occupied beds and listed eight male attendants and two female attendants in care of these individuals. It is not clear if these attendants are acting as nurses or may be doing other jobs. In another section of reports, a clearer understanding of staff roles is seen. A report of the month of March 1867 gives a list of fourteen workers (aside from military members) and shows the distribution as follows: five nurses, five cooks, and four laundresses. That same month, the hospital's average census was approximately 165 patients. This makes a nurse-patient ratio of one nurse for every thirty-three patients. In October of 1867, a list of 22 employees is reported. Of this list three are active duty, eight are nurses, seven are cooks, and four are laundresses.

Image 1 is an example of the employs of the hospital and there role. Patient census for the month of October was approximately 200, making the nurse-patient ratio 1 nurse per 25 patients. There are no other records in the city with which to compare these statistics so it is not known if this was a typical nurse-patient ratio. It appears that it was somewhat difficult to maintain a staff at this facility as monthly reports often list one or two whose contracts were "annulled" for reasons as varied as illness to "habitual quarrelling." One document lists the commission of a medical student to practice as "Active Medical Cadet" and assigned to care for patients at the hospital. It is not clear if these staff members are white or black. One quick ancestry.com check found only one likely link, a nurse named Mary Callom living in Ohio in 1870 and noted to be from Ireland. It is also important to know that the profession of nursing was not yet established as we know it today. At that time, there were no training schools for nurses in the United States.

Therefore, these “nurses” mentioned on the staff log, and many of them men, were likely individuals who were not particularly trained in caring for patients.

| | | | | |
|----|--------------------|-----------|-----------------------------|-----------------|
| 1 | Coyne, Ellen | Nurse | July 12 th 1867 | Ant. Maj. G. E. |
| 2 | Thomas, Stef | Cook | March 4 th | " |
| 3 | Hollom, Mary | Nurse | July 1 st | " |
| 4 | Ogden, Levidia | Cook | June 23 rd 1866 | " |
| 5 | Gratz, Delitha | Laundress | March 11 th 1867 | " |
| 6 | Johnson, George | Cook | Dec 18 th 1866 | " |
| 7 | Johnson, Sarah J. | Nurse | Dec 15 th 1866 | " |
| 8 | Johnson, William | Nurse | March 9 th 1867 | " |
| 9 | Lancaster, Luquise | Cook | Oct 1 st 1866 | " |
| 10 | Lancaster, George | Cook | Dec 15 th 1866 | " |
| 11 | Morley, Andy | Laundress | March 11 th 1867 | " |
| 12 | Ogden, Eliza J. | Laundress | Dec 15 th 1866 | " |
| 13 | Stout, Kenneth | Nurse | July 1 st 1867 | " |
| 14 | White, Kate | Laundress | June 23 rd 1866 | " |

Image 1: List of staff at Freedmen’s Hospital, Louisville, Kentuck, May 1867.

National Archives and Records Administration.

Consolidated
REPORT

Sick and Wounded Soldiers and Freedmen,
Station Louisville
State of Kentucky,
Month January 1867

FORWARDED BY
P. L. Loom
Surgeon in Chief, Dist. of Ky.

Louisville Hospital, Louisville,
Louisville Dispensary,
Lexington Dispensary,
Mt. Sterling Dispensary

1867

I certify that this Report is correct and true to the best of my knowledge and belief.
P. L. Loom
Surgeon in Chief, Dist. of Ky.

REMARKS
The cases reported of dysentery are mostly of the chronic nature, and have been treated with opium, but without success. The cases of cholera are of the Asiatic type, and have been treated with calomel, but without success. The cases of typhoid fever are of the common type, and have been treated with salicylate of soda, but without success. The cases of pneumonia are of the common type, and have been treated with quinine, but without success. The cases of tuberculosis are of the common type, and have been treated with cod liver oil, but without success. The cases of consumption are of the common type, and have been treated with cod liver oil, but without success. The cases of cancer are of the common type, and have been treated with cod liver oil, but without success. The cases of syphilis are of the common type, and have been treated with cod liver oil, but without success. The cases of gonorrhea are of the common type, and have been treated with cod liver oil, but without success. The cases of leprosy are of the common type, and have been treated with cod liver oil, but without success. The cases of smallpox are of the common type, and have been treated with cod liver oil, but without success. The cases of measles are of the common type, and have been treated with cod liver oil, but without success. The cases of scarlet fever are of the common type, and have been treated with cod liver oil, but without success. The cases of diphtheria are of the common type, and have been treated with cod liver oil, but without success. The cases of tetanus are of the common type, and have been treated with cod liver oil, but without success. The cases of rabies are of the common type, and have been treated with cod liver oil, but without success. The cases of hydrophobia are of the common type, and have been treated with cod liver oil, but without success. The cases of cholera are of the common type, and have been treated with cod liver oil, but without success. The cases of typhoid fever are of the common type, and have been treated with cod liver oil, but without success. The cases of pneumonia are of the common type, and have been treated with cod liver oil, but without success. The cases of tuberculosis are of the common type, and have been treated with cod liver oil, but without success. The cases of consumption are of the common type, and have been treated with cod liver oil, but without success. The cases of cancer are of the common type, and have been treated with cod liver oil, but without success. The cases of syphilis are of the common type, and have been treated with cod liver oil, but without success. The cases of gonorrhea are of the common type, and have been treated with cod liver oil, but without success. The cases of leprosy are of the common type, and have been treated with cod liver oil, but without success. The cases of smallpox are of the common type, and have been treated with cod liver oil, but without success. The cases of measles are of the common type, and have been treated with cod liver oil, but without success. The cases of scarlet fever are of the common type, and have been treated with cod liver oil, but without success. The cases of diphtheria are of the common type, and have been treated with cod liver oil, but without success. The cases of tetanus are of the common type, and have been treated with cod liver oil, but without success. The cases of rabies are of the common type, and have been treated with cod liver oil, but without success. The cases of hydrophobia are of the common type, and have been treated with cod liver oil, but without success.

Image 2: Freedmen’s Bureau Consolidated Report, January 1867, National Archives and Record’s Administration.

There exists some evidence of the types of conditions these freedmen suffered.

Image 2 shows the Freedmen's Bureau monthly report with a list of patients at the time of report. There is also evidence of the types of illnesses being handled by the hospital at its closing on July 7th 1868. The list includes 165 men, women and children. The freedmen's ages range from 1 to 112 years of age. This list tells how long the patient lived in the state of Kentucky as well as their home of origin. It also lists the disease they were admitted with, disease upon discharge and "how long standing disease." There is a considerable amount of variation in the diseases listed. Table 4, appendix C, while not exhaustive, gives an overview of the diseases being treated at the Freedmen's Bureau Hospital in Louisville. In the list of patients there are eight cases of frost bite, six cases of "scrofula" (tuberculosis in the lymphatic system) apparently acquired while hospitalized, and ten children that cannot be released due to indigence.

On July 16, 1868 the Bureau instituted yet one more dispensary and appointed a physician, Dr. William Forrester, to act as a "visiting surgeon throughout the city." Apparently, the visiting surgeon made house calls. At the same time it announced the closing of the U.S. General Hospital for Refugees and Freedmen. An entry dated July 16, 1868 states, "This hospital is broken up from this instruction by order of the Asst. Comm. the inmates and attendants being discharged." The closing of that hospital left Louisville's black citizen with no access to hospital care. The Bureau continued on with dispensary services, however. A July 25th report shows that a "Center" dispensary cared for 139 patients, an "East" dispensary cared for six, a "West" dispensary cared for 46 and the visiting surgeon made visits to 66 patients. The east dispensary and the visiting physician had just been established upon the closing of the hospital. On August 1, 1868 the center dispensary reported treating 127 patients, the east 34, the west 83 and the

visiting physician 120. Apparently, with the closing of the hospital, the dispensary and visiting physician services increased.

The dispensary services were interrupted on October 15, 1868 by the closing of the east and west dispensaries. Dr. R.A. Bell, who had been in charge of the west dispensary, was reassigned to the role of visiting surgeon. At the time of their closing, the dispensary officials reported treating a combined 347 patients for the week. Despite the written report of closing, there is a list of east and west dispensaries and patients treated through December 31, 1868. It appears that they continued to administer care in these locations as long as possible. A November 1868 document states that the east dispensary had treated a total of 1358 patients since its opening. With these numbers it is not likely that the dispensaries were closing due to a lack of need.

Finally, there is documentation of the pieces of property left from the hospital, its condition and its disposal. All items were listed as “old and broken” and “to be buried and dropped from the return.” The items mentioned are such items as pots, utensils, clocks, towels, and spittoons. It is not clear, in this source material, why the hospital and dispensaries closed in Louisville, Kentucky. It appears, by the records, that they ceased to exist after December 31, 1868, however, and the care of the city’s black population was placed in the hands of the city officials. As of that moment, January 1869, there were no black physicians in the city of Louisville and the city’s indigent hospital, Louisville Marine Hospital (later City Hospital) only treated black mariners but not black citizens.

City Officials Take Over 1869-1888

Once the responsibility was placed in their hands, the city officials did address the

care needs of the black population. In the municipal report for the year ending December 31, 1868, the Trustees of the Louisville Marine Hospital (later to be known as “City Hospital” and even later “General Hospital”) discussed the issue candidly. The hospital officials recognized that the hospital and health needs of the black community would have to be included in the work of their organization. The hospital official states, “We would remind you that the recent revelation in our midst, by which slave has been freed, has also placed him in a condition that will compel us to provide for him hospital accommodations” and “he, alike with our own race, appeals to your humanity in this hour of sickness, poverty and distress.” The author goes on to advise that the current facility does not have enough space to house the demand of another group of people. It is advised that the hospital be enlarged and “have an apartment for the sick of this character.” The author argues that creating an entirely new facility for the black patients is not feasible as it will incur the costs associated with staffing and running of a second facility. He further argues that the hospital has housed black marines in the past and “there is none that has a feathers weight with it” (Louisville Municipal Report, 1868, UARC). It appears by the record, that the city hospital did not begin taking black patients until the added space was built, or possibly as late as 1869. It is not until 1871 that a hospital census shows the racial make-up of patients in the hospital at the close of the year:

Table 5: List of patients at City Hospital Lousiville, 1871

| | |
|----------------|----|
| Irish Adults | 68 |
| Irish Children | 11 |
| German Adults | 23 |

| | |
|-------------------|----|
| (Continued) | |
| German Children | |
| American Adults | 8 |
| American Children | 61 |
| Negro Adults | 18 |
| Negro Children | 17 |
| | |

(Louisville Municipal Reports, 1871, UARC)

These numbers suggest that either the black community was not seeking care at the hospital (although there was no other hospital for them to seek care) or there were a limited number of beds available to them at the Louisville Marine Hospital.

It appears that the city also took over the task of dispensaries once carried out by the Freedmen’s Bureau. In the health officer’s report of 1868, he urges the city to establish dispensaries under the Board of Health. He states, “I think the parties now conducting dispensaries in the city would cheerfully work in connection with your honorable body” (WPA 12-5 1869). This statement appears to be referring to the Freedmen’s Bureau which already had dispensaries running. In the Physician’s Report to the Honorable Mayor and the General Council the following year, he boasts, “Six thousand sick poor have been treated in our city this year by four dispensaries alone (much of this sickness may be traced to circumstances peculiar to the poorer classes of all large cities—the food they eat, the water they drink, the air they breathe and the houses they live in)” (Louisville Municipal Report, 1869, UARC). It is not clear if these dispensaries serve both black and white patients. There is no evidence that the city

picked up the work of the visiting physician which the Freedmen's Bureau had been conducting, either. It appears that it did not.

Another area that the city was forced to assist the freedmen in was in fulfilling the needs of those who were elderly and had nowhere to go. In his report to the city, Almshouse director John O. Reilly bemoaned the need to admit a black woman because there simply was no other place for her to go. He warned that unless something was done, it would be necessary for the Alms House to begin taking black residents among the whites. He states, "As it now is, the keeper of the Alms House is compelled to receive them, there is no alternative but to place them with the whites. This is objectionable and should be attended to in time" (Louisville Municipal Report, 1868, pg. 8). A building specifically for black residents was built in 1870 (Louisville Municipal Report, 1870).

In the years after the Freedmen's Bureau exited Louisville, many diseases plagued the citizens of Louisville, both black and white. The earliest mortality statistics which bare reference to race are recorded in 1867. Of the 2451 deaths in Louisville that year, 1129 were black citizens, or 46%. The biggest killers were pthithis pulmonalis (tuberculosis) at 303 deaths, stillbirths at 183, scarlet fever at 178 deaths, pneumonia at 158 deaths, cholera infantum at 121 deaths, convulsions at 116 deaths, acute dysentery at 56 deaths and acute diarrhea at 39 deaths (Louisville Municipal Report, 1867). The trend continued and in 1875 the greatest deaths again occurred from "consumption" or tuberculosis, 93 deaths from scarlet fever and 15 deaths from small pox (WPA 11-98, 1875). In addition to these statistics, the health officials reported that one fourth of the deaths that year had no medical attention. This is interesting because at that time, aside

from the work of the dispensaries (which it is not clear they continued to exist or whether they were treating black patients) the only black physician in town was a Dr. Henry Fitzbutler.

Dr. Fitzbutler was born in Amherstburg, Canada to an escaped slave from Virginia, and an indentured white immigrant from England, in 1842. He was the first black graduate of the University of Michigan Medical School in 1872. He came to Louisville directly after graduating medical school. Family legend says that his mentor, Dr. Pearson of Amherstburg, urged him to, “help his people in the south, where there was heavy suffering in an epidemic of yellow fever that struck in 1871 (Hanawalt, 1973). A look at the 1871 Louisville Municipal Report does not corroborate this, however, for the city of Louisville. He became the first black licensed physician in the state of Kentucky (Meyer, 2006). While his practice was very likely needed, Dr. Fitzbutler would not have had privileges in any of the city’s white hospitals and there were no black hospitals at that time. These conditions likely restricted what he could accomplish. It would be over another decade before such a facility would be established.

Meanwhile, the state of health for Louisville’s black community remained endangered. An 1877 mortuary report reveals that out of 1,989 deaths that year, 44% (607) were black (WPA-12-6, 1877). Although deaths due to small pox had been reported in prior years, no deaths occurred to small pox that year due to a system of quarantine started in 1873 at the St. John Eruptive hospital, fully staffed by nuns. The hospital did admit black patients with smallpox. The health officials were exasperated with efforts to vaccinate the public, however, and noted that “under our present authority it is almost impossible to secure complete protection of the community by vaccination,

owing to the ignorance, prejudice, superstition and carelessness of a certain portion of the people” (WPA 12-6, 1877).

The problem of medically unattended deaths was documented again and the health official wrote that the problem was multi-factorial. One problem was that “on account of hard times some postpone sending for a doctor, depending on their own skill, until they find it too late, and others have not the means to procure the necessary medicine and nourishment if they had a physician.” The author goes on to note that it is the fault of the people that no medical attention was given and sites another probable cause, “It is not generally understood that all deserving cases of charity will be given medicines free of charge at our City Hospital on the prescription of any physician endorsed by the Charity Commissioner of the district” (WPA 12-6, 1877). Therein lies indication that the dispensaries aforementioned were likely no longer in existence and that to receive the free medication an individual need see a doctor and obtain a prescription “of any physician endorsed by the Charity Commissioner of the district”. This knowledge, alongside the knowledge that the only black doctor in town would need to be endorsed by the commission, leads to the conclusion that basic outpatient medical care was extremely difficult to obtain for the average black citizen in Louisville. Unlike today, where a patient can go to the hospital emergency room to seek care (although not advisable), the ill individual of that day would have been turned away from the hospital. The City Hospital admitted only indigent individuals that needed hospital care. Furthermore, it appears that it had limited space for black Louisvillians.

To compound the issue, the city abolished its health department in 1877. The health department oversaw vaccinations, monitored and regulated sanitation ordinances,

collected health statistics and essentially helped to control disease in Louisville. The city officials decided that the expense was too great for the budget and closed the department. Sanitation control was handed over to the police department to manage. An epidemic of yellow fever ensued the very next year. City officials ordered that the St. John Eruptive Hospital (for smallpox) be “carefully cleaned, fumigated, and prepared for the reception of yellow fever patients” but before that could be completed patients began to flow in. They were placed in “old buildings” and a temporary facility of 50X34 feet was “rushed up”. Within a few days both buildings were filled with “refugees stricken with the disease” (WPA 11-95, 1878). It is not clear how many of these “refugees” were black, if any. Needless to say, the city re-established its Board of Health by January 1878 and resumed its previous work.

The work of the city’s Board of Health was not easy, however, and some residents appeared to be of lesser importance to city officials than others. The following incident which happened in the section of Louisville where “negroes” resided (10th Street and Green Street), demonstrates this disregard for the well-being of some citizens. The archive material is not clear if this section of living quarters was inhabited by blacks or by another group of people, but it does demonstrate how the city officials overlooked certain neighborhoods.

They also prevented the drainage of the lots so that some to the some of the families could scarcely walk in their lots at times, because of the undrained condition of the grounds. Privy pits that had been cleaned under the orders of the Health Officers, were filled with water and made to overflow, and all this was done by the city authorities. If they failed in any one item in securing death and

disease among the people who had entrusted their health and lives to their care, we have failed to discover where they faltered in the work of destruction... In July and August the Board of Health made earnest efforts to get the perilous state of things on Green and Tenth Sts. removed. All efforts were futile. No one in the city Government who was urged to attend this danger paid the least attention to the appeals of this Board for saving the life and health of the people of that locality. Not a single effort was made to respond to the pleading of members of the Board of Health. On the 21st of August at the regular meeting of the Board, the perils of that locality were fully discussed. It was pronounced the most dangerous spot in the city. The engineer that had devised this death-trap was denounced in becoming terms. On the morning of the 22nd of August, the city papers published the facts uttered at the meeting of the Board, with the admonitory warnings directed to the city authorities. Not the least motion was made by the Council to save the imperiled people of Tenth and Green from the impending angel of death, who was thus permitted, by criminal neglect, to plume his wings for a mission of devastation. Week after week rolled on, showing all who looked upon the scene that all efforts at blowing the breath of life into the dry bones of the city authorities was utterly futile. The shameful, culpable nuisance was permitted to lie in the sunshine and rain undisturbed for one month after the Board of Health gave a public notice of it. About the 20th of September, the thermometer showing the peribus daily mean of about 66 degrees throughout the month of September, cholera began to riot among the festering decompositions created by the city. We think that there is scarcely a possibility of finding

anywhere a more perfect specimen of official apathy, of utter indifference to all appeals and expostulations than was shown in this entire business... If it had been possible for the city authorities to add to the profuse material they supplied for the destruction for the people on the corner of Green and Tenth, a daily mean of eighty degrees of solar temperature during the month of August and September, they would have manufactured yellow fever for those people instead of cholera...A portion of the city officials performed their part in furnishing materials for sickness; and death with gratefulness. We have thus given the undisputable facts of this harrowing subject. Until experience forced the facts upon us we could not have believed that there existed in a civilized city the heartless indifference to human life that we found in this case. It was the slaughter of innocents without even the excuse of King Herod.” (WPA 12-2, 1886)

The gutter drainage had been stopped at this location and the health officials sought intervention by the city sanitary engineers in July of that year. Nothing was done, and through the months of July, August, and September sewage began to build up. The city health officer had asked the city engineers to address a sanitary dilemma at that location. Correction of the problem did not happen and the health officer became disgruntled, sarcastically stating, “we proceed to the painful duty of giving a thorough exposition of the events connected with the slaughter of the people on the corner of Tenth and Green”. The health official accused the city engineer of dumping refuse in that section, leaving it and not responding to their cries to have it removed. An outbreak of cholera ensued. This incident demonstrates the lack of concern city officials had for many of the city’s

marginalized residents.

Another topic that deserves mention, occurring throughout this era, is that of experimentation on black residents. The idea of the black body being used for experimentation is not new (Blakely & Harrington, 1997; Jones, 1992; Washington, 2006). During the 19th century, slaves were often used for medical experimentation. Furthermore, the idea of being snatched at night for use as a cadaver to be studied by medical school students was a serious fear among southern black residents of the late 1880's (Savitt, 2006). It appears that residents in Louisville may have reason to fear similar fates.

In 1870, Louisville Medical School enjoyed the assistance of what was often called a "resurrectionist". The resurrectionist was paid by the medical school to visit freshly dug graves during the cooler months and procuring for the school, fairly fresh cadavers for dissection. A gentleman named Simon Kracht was the name of the individual who held this position at the University of Louisville Medical School. Mr. Kracht would visit the grave of a recently deceased (often someone of poor background) individual and dig them up to be delivered to the medical school (McQueen, 2001). These resurrectionists would notoriously obtain their specimens from the poorest of burial grounds because these would be the least noticed and have less likelihood that the deceased's family would retaliate. Often times this would be black individuals (Cox, 1986). It is not known if this was true of Simon Kracht and his practices but a few clues tell us it is very likely. It appears that the city maintained a burial ground in which they exclusively buried black paupers. This burial ground was located on the south side of Jefferson Street, between Seventh and Eighth Streets (where the probate court building

now stands). In an address to the Board of Health, a sanitary officer mentions that the graves of this burial ground have been dug far too shallow. He reports that internments were being made anywhere from six inches to two feet below ground. This was far below the recommended six feet of earth. Could it be that these short depths of graves were purposeful? Was Simon Kracht commissioned to go to this site and retrieve the freshly, and shallowly, buried body for dissection? We may never know.

Only one other piece of evidence points to this possible conclusion and that is of an article written for the Cardinal (the University of Louisville paper) ca. 1919. The article describes a visit by the journalist to the medical school cadaver lab to witness the schools' process of acquiring and housing "stiffs". He meets and interviews Dr. S. I. Kornhauser, who was head of the anatomy department. While interviewing Dr. Kornhauser, the young journalist is shown a cadaver, "On a table lies the dull black body of a negro man." Dr. Kornhauser and the embalmer, Gus, admire the body: "That certainly is a nice body." "Yes sir! Nice and developed, no fat either." Dr. Kornhauser tells the journalist that the bodies are procured after being unclaimed from City Hospital within three days of their death. This particular body had been found shot at the fairgrounds.

In *Bones in the Basement*, Blakely and Harrington examined the remains discovered in the basement floor of the Medical College of Georgia, in Augusta. The building had been used as the medical school home during the 19th century and when renovating, the remains of multiple human bodies were found. These bodies turned out to be predominately black (male) and were the cast offs of previous medical student dissections (Blakely & Harrington, 1997). It is very likely that the Medical School of the

University of Louisville may have had a large portion of black cadaver bodies since the City Hospital housed black and white patients since 1869 and the indigent black individual was less likely to have the family or means to dispute the case.

Those who took on the role of caring for the city's black population were few in quantity. Dr. Fitzbutler was joined several years later after his arrival by one other black physician but the two physicians, alone, were not sufficient for the health needs of Louisville's black community. Aside from hospital care at the City Hospital, if indigent, black patients had nowhere to seek inpatient care. During this time, various religious institutions and other organizations in the city began to set up hospitals of their own. All of these facilities were solely open to white patients. St. Mary and Elizabeth Hospital was opened in 1874 and located on a lot that stretched down Magnolia Street between 11th and 12th street. The Home for the Aged and Infirm opened in 1874. The John N. Norton Infirmary located on 3rd and Oak Streets opened in 1882. The Children's Free Hospital, at Floyd and Chestnut Streets opened in 1892. Methodist Deaconess Hospital opened in 1896 on South Eighth Street (Elva Lyon's Papers Collection, 1937-1942). This demonstrates the change from care for individuals being given at home to caring being administered in hospitals. *In Sickness and in Wealth*, 1989, author Rosemary Stevens describes the change in hospitalization as one from an indigent asylum to one of scientific modernity. She describes the change as a testament of the modernization of America, and aligns it with the advent of the factory, the hotel and the symphony (Stevens, 1989).

A Medical School 1888-1900

During this period, the nation began to see the passage of laws meant to ensure

that segregation remained deeply embedded in the social fabric of the southern region. Often labeled “Jim Crow” laws, these laws were passed under the premise that blacks maintain a “separate but equal” world (Woodward, 1995, p. 71). The separate but equal dealings were deemed to be out of the jurisdiction of the U.S. Supreme Court in a ruling of the case of *Plessy vs. Ferguson* in 1896 and the states received the green light to continue with their race dividing legislation. Kentucky was one of those states creating such laws. Kleber (1992) writes, “although Kentucky had not left the Union, slavery had been a major feature of its society, and the enfranchisement of blacks caused widespread resentment” (p. 808). In 1892 the state passed a separate coach law to require that blacks and whites not be on the same coach (Kleber, 1992).

In Louisville, by the late 1880’s, the first black physician, Dr. Henry Fitzbutler, had established himself as a leader in Louisville’s black community. He had already become involved in matters of education for the black community, and established a newspaper, the Ohio Falls Express, all while maintaining his physician practice. One account states that the young physician had “attracted much attention” to himself upon arrival being the “first regular physician of the colored race to enter upon the practice of medicine in the state of Kentucky” (Hanawalt, 1973). This same account suggests that Dr. Fitzbutler may have had opposition from both the white and black community. Apparently, during the years when Fitzbutler first arrived to Louisville, there was an “admitted guardianship...group of prominent men who dictated public affairs for the colored people in a manner agreeable to the prejudices of the white people.” In essence, Dr. Fitzbutler’s push for improvement of the life of Louisville’s black citizens may have seemed to forward for some and he was likely not expected to last, being a “damn

yankee” (Hanawalt, 1973).

Obviously a bright and talented individual, Dr. Fitzbutler was frustrated with his lack of opportunity as a physician and of the poor medical care being offered to the black community. The following story, provided by his granddaughter in 1952, is a prime example of the attitudes of whites, especially white physicians, of that time:

In 1877 a French family named Frivall lived next door to the Fitzbutlers at 1113 West Madison Street in a two story brick house. There were nine children in the family, ranging in age from two to twenty years. One day the clothes of the third child, Lillian, about sixteen years old, caught fire while she was cooking. Engulfed in a mass of flame and tearing flesh from her hands and body in frenzy, she rushed outside. In the ensuing neighborhood excitement, everyone sent for his or her doctor. In a short time about eight were on the scene. Dr. Fitzbutler was the fourth to arrive and the only one equipped for action. He had brought a large quantity of linseed oil and lime water and a roll of cotton. While the white physicians were debating what course would be best to follow and discussing moving the patient to a hospital, Dr. Fitzbutler went to work. Turning to the assembled doctors he asked, ‘Will one of you assist here?’ The reply was ‘We won’t work with a Negro’. Dr. Fitzbutler steadfastly continued the necessary removal of the child’s clothing and tedious work of debridement, and applied soothing dressings. When the patient had at last become calm, the white doctors demanded that Mr. Frivall dismiss the Negro doctor, one of their number saying, ‘I’ll serve you.’ The father, now irate, replied, ‘Do you know of anything better? What do you do? You stand, you talk, my child dying. Now hear what you say.

Go! Clear out of my house. Dr. Fitzbutler, God bless you, we do what you say.
(Cobb, 1972, p.405)

The refusal of the white doctor to even assist Dr. Fitzbutler in caring for the burned patient demonstrates how white health professionals carried the assumption that it was undesirable to interact with black residents, even black physicians.

Dr. Fitzbutler was eventually joined by Dr. Rufus Conrad. Both physicians took to apprenticing other young potential doctors. Eventually, they partnered with their New Albany, Indiana neighbor physician, Dr. William A. Burney and approached the Kentucky state legislature for a charter for their school, The Louisville National Medical College. The school would be open to all races. Not long after opening it began admitting women, also. The school was the only medical school started by and operated by blacks. Other black medical schools existed, such as Meharry in Nashville, Tennessee and Howard in Washington, D.C., but no other existed that was the product of work by black individuals alone (Savitt, 2007). Certainly nothing in the literature indicated that Dr. Fitzbutler had an ounce of assistance from anyone in the white community.

The charter was granted, and the Louisville National Medical College opened in Louisville Kentucky in 1888. The school flourished and graduated six doctors in 1889, two in 1890, four in 1891, six in 1892, four in 1893, seven in 1894, six in 1895, six in 1896, six in 1897, five in 1898, and four in 1899 (20th Annual Announcement of Louisville National Medical College, 1907). Dr. Fitzbutler's wife, Sarah, became the first female graduate in 1892 and began practicing in the community. Often uncompensated, she would make visits to the city's tenements and back alleys

(McConnell, 1983). Apparently the quality of the education being delivered at the school was at least standard or above. It was the responsibility of the State Board of Health to assess the worthiness of degrees of medicine bestowed upon new graduates of any medical program in the state and the Louisville National Medical College boasts this in their 1894-1895 catalogues:

And that each and every one of the graduates of the LOUISVILLE NATIONAL MEDICAL COLLEGE received a regular certificate from the State Board of Health of Kentucky, held April 1891, the LOUISVILLE NATIONAL MEDICAL COLLEGE was indorsed and declared to be a regular legal medical college, commended to Kentucky and to the world.

(Cobb, 1952, p. 406)

Because there was only one hospital for black patients to be treated (City Hospital) and no hospitals in which black doctors had privileges, it became necessary for the leaders of the Louisville National Medical College to establish a hospital. The Kentucky State Board of Health mandated, in 1895, that all medical schools in Kentucky have hospital privileges for its students in order for students to receive certification from the Board to practice medicine. The school leaders, under the management of President Dr. Henry Fitzbutler, rose to the occasion and the Auxiliary Hospital opened in September of 1895 at 1027-1029 West Green Street (now Liberty Street). A Report of the Auxiliary Hospital 1895-1901 reveals the following information: It was located next to a picturesque park and its patients had free access. The expenses were met by the Louisville National Medical College (although one source (Cobb, 1952) says that Dr. Fitzbutler funded it largely from his own estate). It took few individuals with cases of

acute infectious or contagious disease. It had an extensive surgical suite with the latest in light, heating, ventilation, table, sterilizers, irrigators and instruments. Surgical operations ranged from appendectomies to amputations, hysterectomies to amputations, and arthrectomies to reductions of fractures. The lying-in (obstetric) department reported only two deaths in the six years of running. It had a dispensary that was open from 0800-1000 with “free medical and surgical treatment and vaccination is furnished to the indigent”. There was a practical nurse training program and nursing students were also going out into the community to make visits. The hospital was fully public with private rooms provided on an as needed basis. It is not clear how many beds the facility had, but the census overview details treating a total of 924 patients over the six year period. Of those 924 patients, 665 were cured, 169 improved, 67 unimproved, and 25 died. Some of the most common cases (showing ten or more) being treated were bubo (lymph swelling), influenza, lagrippe (apparently also the flu), gonorrhea, pharyngitis, renal insufficiency, contusions, lacerations and incised wounds and gunshot wounds (Report of the Auxiliary Hospital, 1901).

The Louisville National Medical College and its hospital continued to thrive throughout the remaining years of the 19th century. Some of its graduates remained in Louisville and increased the number of available black physicians to Louisville’s black community. In his book, *Weeden’s History of the Colored People of Louisville*, H.C. Wheden mentions that at one time the city had eleven black physicians practicing. At the time of his writing, in 1897, he lists the following black physicians: H and J.H. Fitzbutler (Henry’s son), Felix G. Fowler, E.D. Whedbee, A.B. Pruett, E.R. Gaddie, E.S. Porter, M.F. Robinson, H.H. Jones, Mrs. Dr. Edward Warden, and Mrs. Dr. Sarah Fitzbutler

(Henry's wife).

The fact that the Louisville National Medical College had a nurse training school upon opening the hospital is important for the purpose of comparison. At least two other hospitals had nurse training schools in operation at that time. The first to open was Norton Infirmary Nurses Training School in 1887 and months behind it the Louisville City Hospital Nurse Training School. Neither program admitted black students. These two institutions were on the cutting edge of their time in means of hospital care. Nursing was a newly recognized profession and policies governing the qualifications required to practice it were just beginning to form. So, it is encouraging that the Louisville National Medical College Nurse Training program was only a few years behind the white institutions. It speaks well to the determined spirit of those in the black community who sought to push for high quality care for its citizens.

Excluded from the white American Medical Association and the local Jefferson County Medical Association, Louisville's black doctors were involved with the counter organization, the National Medical Association. They hosted that organizations annual meeting in 1899. They, along with black dentists and pharmacists would create their own organization over the next few years which came to be known as the Falls City Medical Society (Morris, 1987).

A couple of other institutions were established during these years that had an impact on the black community. The results of the work of several black churches, funds were raised to establish both the Colored Orphan's Home (1878) and ten years later the St. James Old Folks Home (1888). The old folk's home ran into financial difficulties and was forced to close in 1890. Several women's groups began to raise money and re-

opened the home. The women's group was so savvy in managing the financial affairs of the home that they were able to purchase additional property to expand the home and pay of the mortgage within five years (Wright, 1985).

Another institution which served the black community was established during this time, as well: The Presbyterian Colored Missions. In 1897, Presbyterian Pastor John Little, a white man, conducted an informal survey of black citizen's in his endeavor to open a Sunday school class for black children. He writes that he was appalled at what he witnessed. His testimony describes unclean homes with the influence of criminal activity and prostitution. He claimed that black homes were full of "poverty, ignorance and sickness" (Gaines, 1933). He initially set up a settlement house on Hancock in what was the "east end" of Louisville at that time and named it Hope Mission. A second settlement house was established shortly after, in 1899, in the Smoketown neighborhood at Hancock and Roselane. This settlement he named "Grace Mission Station". Together, the settlements came to be known as the Presbyterian Colored Missions, or the John Little Missions. The initial intent was to educate the black citizens on issues of cleanliness and skills. Boys learned basketry, tailoring, shoe repair and carpentry skills. Girls learned cooking, sewing and similar trades. Special attention was placed on teaching proper hygiene with cooking and proper diet. Eventually, Grace Mission would include medical care among its services offered (Wright, 1985).

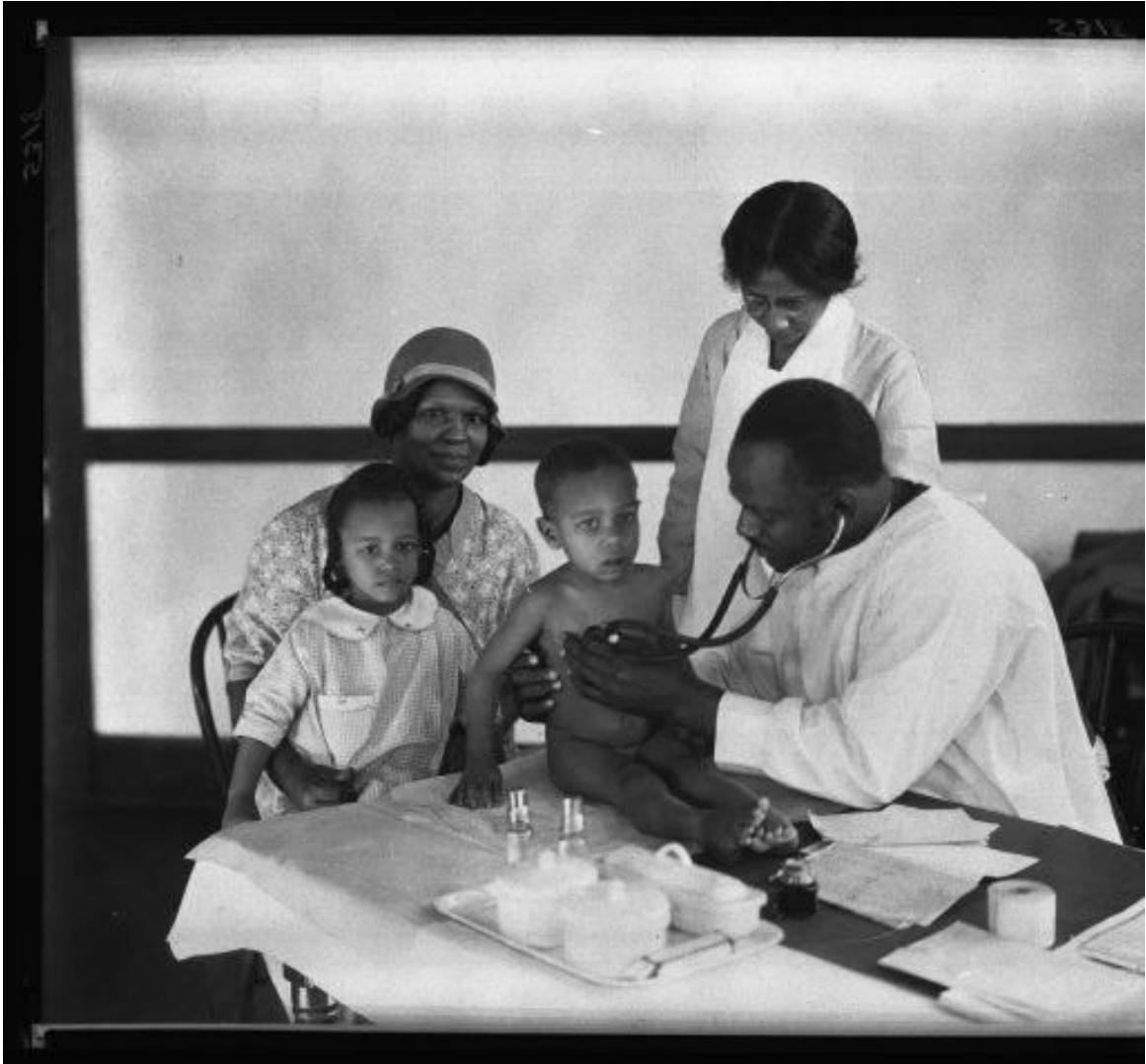


Image 3: Clinic at Presbyterian Colored Mission, 1930 (University of Louisville Digital Archives)

Interestingly, it was at the close of the 19th century that yet one more black institution made its beginnings, the Red Cross Hospital and Nurse Training School, who opened its doors in 1899. “Born out of the need of medical care facilities where the negro doctor could not be rendered in the home”, it was initially established in a one story, four room frame house on 6th and Walnut St. (Johnson, 1965). It resulted from the combined efforts of Dr. W.T. Merchant, Dr. Ellis D. Whedbee, and Dr. R. B Scott. In

addition to the hospital, these physicians opened the first black drug store in Louisville on 12th and Walnut Streets. The funding for these efforts were garnered by civic and church groups, holding fish suppers, teas and raffles (Johnson, 1965; Wright, 1985). One would think that the plight of Louisville's black community was off to a good start at the dawn of the 20th century. With two hospitals, two nurse training schools, an old folks home and an orphanage and several doctors in the community it would appear that it was moving in the right direction to meet the needs of the black community.

The dawn of a new Century 1900-1920

During this era, black Americans began to leave the rural Southern United States for urban areas in other parts of the country. Prior to this time, an overwhelming portion of black Americans lived in the south. Referred to as the Great Migration, this concentration of blacks in the Deep South changed during the 20th Century (Gregory, 2005). Louisville became home to many of these folks and by 1930 had tripled its black population (Aubespain, et al., 2011; Adams, 2010).

Laws designed to uphold and ensure segregation continued to be enacted during this time. Kentucky passed its Day Law in 1904. A state representative visiting the interracial (at that time) Berea College saw that black and white students were being educated alongside one another and was appalled. He quickly wrote a bill that would make it illegal to teach black and white students together in Kentucky (Kleber, 1992). While there appears to be no laws regarding the practice of medicine, hospitalization or healthcare provisions, there remained a strict divide among the city's hospitals. With the exception of the city's indigent hospital, whites went to white hospitals and blacks went to Red Cross Hospital.

At the dawn of the 20th century, Louisville's black community had access to two hospitals, an old folks home and an orphanage open entirely to them. In addition, black Louisvillian's who were unable to pay for medical needs had access to the city's indigent hospital, City Hospital. There were at least twelve black doctors to choose from, as well. The years 1900-1910 were probably the most hopeful in terms of health care for Louisville's black community. Unfortunately, they were not destined to last.

The Louisville National Medical College was garnering great success by the turn of the century. It had already produced fifty-six black physicians, including Dr. Fitzbutler's wife and son, a few of whom remained in Louisville to practice and teach at the school. In 1901, Dr. Henry Fitzbutler died of chronic bronchitis. The school and the hospital appeared to continue to thrive after his death. That same year the college was remodeled and improved laboratories were installed as well as a library and a dormitory for students. In 1903 the school merged with the State University, the city's black college, and became that school's medical department. Once combined with State University (later Simmons University) the school began to offer degrees in pharmacy also. The hospital was moved to a building adjoining the medical school and renamed Citizens National Hospital in 1905. The first official graduates of its nursing school were listed in the 20th Annual Announcement brochure and were as follows:

Gannaway, Callie P. (1901).....Louisville, KY

Green, Mary Etta (1902).....Louisville, KY

Goatley, Ida (no date).....Louisville, KY

It is not clear if there were nursing graduates before this, indeed the hospital opened with a nurse training school in 1895, or if these were the first and only graduates of that

program (Meyer, 2006). Furthermore, documentation of the total number of nursing graduates from Louisville National Medical College remains absent.

The medical school required a minimum of a bachelor's degree for admission, a diploma from an accredited high school and examination in Math, English, History, Language (with minimum of Latin), and Science. The school also required two certificates from "reputable" instructors recognized by any State Board of Medical Practice. In 1907 the school could boast that all of its students had successfully passed State Board examinations where they were subject to being taken (apparently, some may not have been subjected to state examinations). Furthermore, the school was recognized by "all State Boards" and was "in good standing with all Medical Associations" (Meyer, 2006).

In the 20th Annual Announcement, the following is written regarding the hospital:
We wish to call attention to the fact that this is one of the very few Medical Colleges in America that own and operate a hospital.

Many mention hospitals they are privileged to use, but in such cases students are usually admitted once or twice a week, whereby selected cases are lectured upon in an amphitheater; the same patient is thereafter seen only by the internes who are privileged to note the treatment of every day progress of the case; and it is they alone who get the benefit that of right belongs to the general student.

In Germany all medical teaching is reinforced by the bedside clinics. Hence, thoroughness of those institutions. To make our students proficient and thorough in both science and art of medicine, we have adopted the German

method of teaching medicine and have at very great expense built and equipped a thoroughly modern and up-to-date hospital—it is no exaggeration to say that no hospital anywhere is in any respect superior to it; wherein we assign to advanced students, who were divided into sections—certain wards who under the guidance of the faculty, diagnose, prescribe for and treat the patients therein from the time they enter the ward until they leave, carefully noting the effects, favorable, or unfavorable, of the drugs used. When they have been thus drilled by actual practice they will feel fitted to enter the sick room of their patients without misgivings.

Physicians and surgeons of the Falls Cities are cordially invited to visit and inspect The Citizens National Hospital, located at 112 West Green Street. Modern in every respect, electric lights, and call bells, baths, steam and natural gas heated, hardwood floors male and female wards, fine private rooms and the best equipped and finest operating room in the South and West, which is at the disposal of all reputable physicians, the only charge being for actual cost of material used in the operation.

The clinical material is unusually large and varied. Louisville has a population of over 300,000; 50,000 of whom are negroes. The college and hospital is in the thick settlement of negroes, who daily throng the Free Dispensary of the College. Clinics are so numerous, that each individual student is able to examine patients thoroughly. The Seniors make ward visits in divided classes, and thus keep track of all hospital patients. It will be impossible for a student to take the course we offer and not to be well grounded in both practice

and theory. (Louisville National Medical College 20th Annual Announcement, LNMC Collection, KLHC)

These excerpts leave the impression that the school and the hospital were doing exceptionally well. It seems almost a challenge to the white physicians' community when the author states, "Physicians and surgeons of the Falls City are cordially invited to visit and *inspect* The Citizens National Hospital." Similar accolades were not being said of Louisville's other teaching hospital, City Hospital (formerly Louisville Marine Hospital). In fact, rumors were circulating that spoke the opposite of City Hospital. In a response to accusations within the community about City Hospital being a "slaughter house", Dr. D.W. Yandell (on staff at the hospital and instructor of medicine) was interviewed by the Courier Journal and argued that the allegations of the hospital being a "slaughter house , and by inference the surgeons being butchers" was untrue. He contradicts charges of "unsanitary condition of the hospital, with its old and filthy walls, and the resident graduates being allowed to do major operations, and the carelessness and inattention of the visiting staff" (WPA-10-57, 1886). Nonetheless, the City Hospital and University of Louisville Medical School had apparently developed a negative image among the community. Similarly, while describing the options of the black citizens of Louisville in regards to health care, a journalist wrote that the Red Cross Hospital offered refuge from the City Hospital "which a quarter of a century ago was haloed in sinister rumors" (Courier-Journal, Feb. 1, 1925). One can wonder if the aforementioned statement by the Louisville National Medical College author (in the annual announcement) was in snide recognition of this image of City Hospital and the associated

University of Louisville Medical Department. In taunting fashion, the writer beckons those of the white teaching hospital to come and “inspect” the premises of Louisville National Medical College.

While Louisville National Medical College and its Citizen’s National Hospital were enjoying its peak of success, the other black hospital, Red Cross Hospital, was getting its bearings and creating its own future. It is unclear why the founders of the Red Cross Hospital sought to open another black hospital as opposed to investing in the Citizens National Hospital already in existence. The three doctors who initiated the project were all from the southern United States. Perhaps there was some connection to this as Dr. Henry Fitzbutler was of a northern raised background. By 1905, the hospital moved to a new location on Shelby Street. Realizing that the citizens to whom the hospital provided for often had insufficient means to pay, the directors decided to bill patients at only 75% the charges of other area hospitals (Wright, 1985). In 1904, it officially opened its nurse training program. It was around this time that the hospital directors began to seek the assistance of the white community. A big contributor and supporter was the prominent white philanthropist and descendent of the aristocratic Speed family, Louise B. Speed. In a newspaper article, Speed recalls receiving a postcard requesting her help from the Red Cross directors in 1908 to which she claims she quickly responded to (Courier-Journal, 1920). Another regular contributor and supporter of the white community was Miss Lucy Belknap (Wright, 1985). For both of these highly influential women, it appears that the question of segregated care never arose. Segregation was the norm of the time and these two ladies worked to ensure that black patients had some hospital to seek care.

In 1911, through the efforts of Miss Lucy B. Belknap, the Red Cross Hospital recruited the state's first registered nurse to head the nursing department. Miss Mary E. Merritt, educated at Berea College and Freedmen's Hospital, arrived at the Red Cross Hospital to find a less than desirable situation. She recalls finding an institution that accommodated twelve people. The instruments and surgical supplies had to be sterilized on the kitchen stove and they only had kerosene lamps for light. Undeterred, she put in her best effort and within a few years there were improvements in the condition of the hospital (Souvenir, 1939). This shows that the facilities, while more than many black communities had, were poorly funded and perhaps often inadequate. There is no comparable documentation of white hospitals of the time except the rumors surrounding the medical care at the City Hospital.

Meanwhile, the only other hospital accepting black patients in the early part of the 20th century was the Louisville City Hospital. For the year of 1900, the hospital admitted 1,386 whites and 732 colored patients. For that same year, the hospital reported 169 white patient deaths and 135 black patient deaths, or 12% and 18% respectively (WPA 10-57, 1900). City-wide statistics for 1901 were worse. The death rate for the city's black population was 43.4/1,000 to the white populations 11.9/1,000. That same year, the city coroner reported that 349 of the 556 inquests (over half) were held on black patients at death. That was nearly twice the amount of white patient inquests of 207. Top reasons for death that year, aside from casualties of disease, were suicides, drowning, murders and other accidents (Louisville Health Department Annual Report, 1901). The hospital facility had become worn out and could not hold the high number of patients that sought care at City Hospital, so in 1910 the city began to plan for a new

building. A campaign was conducted for a million dollar bond which was unsuccessful initially. During the second campaign, the city officials garnered support from the local black physicians by promising them that they would have recognition and a place in the new City Hospital. The black physicians did work hard for this bond, which was successful, and a new facility opened in 1914. The promise, of recognition of black physicians however, was never fulfilled (WPA 10-60, 1926).

Mortality statistics were improved by 1903 but black Louisvillians still had nearly twice the death rate of white Louisvillians, 24.78/1,000 to 14.9/1,000. Dr. M.K. Allen, health officer at that time, gave the following explanation of the difference:

I have accounted for the high death rate as occurring in our colored population by reason of the fact that many of this class of people are improvident, ignorant, uncleanly in person, and indifferent to hygienic precautions, and besides they indulge in excessive venery and other hurtful practices. Many of them have inherited tendencies to scrofulous and tubercular diseases. It is not surprising, then, that the death rate is much greater in the colored population than in the white. (Louisville Department of Health Annual Report, 1903)

Two more entries in this report demonstrate the assumptions about black people by this health officer:

A matter which is worthy of consideration in reference to the prevalence of consumption is the high death rate occurring from this disease in the colored race, their being at least one hundred per cent. more deaths among this class of people than occurs in the white race. In this city, where much of the domestic help is colored, is it not perfectly possible that families are endangered to a great degree

from this fact?

At least two free public bath-houses should be erected for the sole use of the colored population. Or, if this cannot be done, the bath-houses should be so arranged in construction as to accommodate the white and colored population separately. This is the very class of people who should be taught the habits of cleanliness. It cannot be estimated as to how much of this would contribute to the healthfulness and activity of this class of people and to what extent it would cause them to be more self-sustaining, thus lessening the expense of their maintenance in our eleemosynary institutions. Besides, then, the health-giving benefits to be derived from free public bath-houses, I firmly believe that better citizenship would arise, together with an elevated moral tone, and with the economic idea suggested, should, unitedly, be a sufficient stimulus to cause the erection of additional bath-houses. (Louisville Health Department Annual Report, 1903)

The same health officer makes similar remarks in the next annual report suggesting that black citizens have a higher death rate than whites due to “habit, environment and a general want of knowledge in respect to proper sanitary and hygienic precautions” (Louisville Health Department Annual Report, 1904). He also suggests that the greater population should be concerned about the high rate of tuberculosis among black residents as they are usually employed by whites in domestic positions within their homes and their presence could jeopardize the health of white citizens (Louisville Health Department Annual Report, 1904). It was not until 1911, however, that the first bath house for black citizens in Louisville was established (Louisville Health Department Report, 1911).

In 1908, the Louisville Health Department Annual Report reveals that the rate of death for the city's black population that year was approximately 41 per cent of the total deaths, despite the black population only representing approximately 20 per cent of the total population. The following entry demonstrates more stereotyping by the officials:

This relatively high death rate among our colored people of course maintains the mortality rate of our city at a much higher figure than it otherwise would be, but the undisputed fact that this high death rate among the colored population is due in a large measure to inherent racial weaknesses does not mean that it is a hopeless task to reduce it. While the death rate among the colored people is universally high throughout the United States, much may be done to reduce it by improved sanitary conditions, different environments and an observance of plain hygienic law relating to over-crowding, impure or insufficient air and vicious habits. The two qualified colored physicians attached to the Health Office are deserving of the thanks of the whole people for their untiring efforts to improve the conditions of the members of their race, by impressing upon them the inestimable benefits to be derived from pure air sunlight health environments and good habits.

In the matter of births among colored people reported to this office the same disparity, as compared to the whites, exists, but on an inverse plane. Constituting 20 per cent of the whole population, there is reported to this office less than 10 per cent of the total number of births. There is no reason to believe that this race is less prolific than the white race—rather the contrary—but it is believed that more than one-half of the births among the colored are not reported

at all by reason of the fact that the mothers in their accouchement are attended by unlicensed midwives or pseudo physicians. Such attendants studiously neglect to furnish the certificate required by law in order to avoid being subjected to the payment of a license fee, which is required of all accouchers whether physicians or midwives. (Louisville Health Department Annual Report, 1908)

This last entry identifies the arrival of two black physicians working with the Health Department, their names are not stated however.

As far as diseases are concerned, the early part of the 20th century saw a decline in such problems as cholera and small pox but a rise in tuberculosis. Small pox had not yet been fully eradicated, however, and the St. John Eruptive Hospital still quarantined black and white patients infected with the disease as was the case in 1910 when an outbreak among black residents along Eighteenth Street Road, in a neighborhood known as “Fire-brick clay works” occurred. Only five individuals were affected, all of them black, and they were promptly quarantined. The area brick plant workers were vaccinated and that was the end of that outbreak (State Board of Health Report, 1910-1911).

Tuberculosis was fast becoming the primary cause of death at this time in history and city officials worked with state officials to create the Board of Tuberculosis Hospital. Initially, patients were treated in an annex of City Hospital and a dispensary was created to manage new cases. Eventually (1910), a sanatorium was established ten miles outside of the city on Waverly Hill and patients who were in the early stage of disease were sent there for care. By 1915, the sanatorium was able to expand to a capacity of 170 patients but it is not clear if this included rooms for black patients as well as white. The hospital also sponsored a nursing school (for white students) that was affiliated with Louisville

General Hospital Nursing School (Board of Tuberculosis Hospital, 1915).

Another area of real concern for the city Health Department was the issue of poor housing. Tenements in the city tended to be in very bad shape and a law was passed in an attempt to make the individuals responsible for these living quarters repair them.

Although the law was aimed at the owners of these buildings, the health department felt that much of the problem was the result of lifestyle of the inhabitants:

Another difficulty lies in the fact that it is not always the owner who is responsible for the deplorable conditions found. Often he is willing to put the house in repair, but the tenants tear down as fast as he builds up, burn the new steps and fences, knock holes in the new plaster, and tear off the new paper.

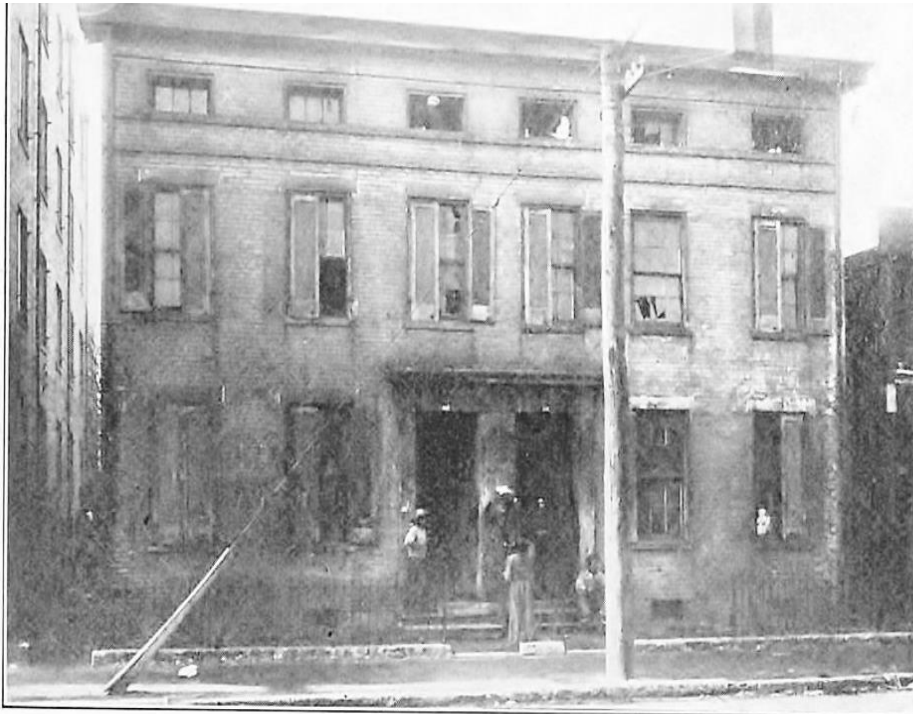
Repeated visits from the tenement house inspector are necessary to impress upon the tenants the fact that they, too, have some responsibility in taking care of the houses in which they live.

This is particularly true of the colored tenements, which make this housing problem even a more complex one in cities with a large colored population. On Pearl Street there are two large negro tenements, popularly known as the "Tin House" and "Cave Hill." These places have been remodeled and repairs so as to bring them within the law, but the tenants are of a low, degraded class of Negroes, who recognize neither moral nor civil law. They live in unbelievable filth.

Repeatedly the Tenement House Inspector visits these houses, orders them to clean up, and personally superintends the cleaning. Within a few weeks another inspection reveals conditions almost as bad. During the coming year the Department of Health is planning to have the Tenement House Inspector make

weekly visits to these back tenements where this class of people lives, hoping that, by constant supervision, it will be finally borne in on them that they must keep their rooms clean. (Louisville Health Department Annual Report, 1913)

An example of the deplorable conditions can be seen in Image 4.



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Negro tenement at 414-416 South Brook Street ordered wrecked by Health Department.
This house was in such a wretched state of decay it was impossible to ever bring it within the law.

Image 4: (Louisville Health Department Annual Report, 1913, p. 16. KLHC)

While the Health Department continued to address the issues of disease and sanitation things were not going well for the Louisville National Medical College. No record exists to explain the demise but speculation has centered on the likelihood that it, like many other black medical schools, suffered the blow administered by the Abraham Flexner report of 1910 (Savitt, 2007; Seyal, 2006). Flexner, a Louisville native, is credited with setting standards for medical school entry and conduct throughout the

United States after his study of existing medical schools in the United States during the early 20th century and subsequent report, *Medical Education in the United States and Canada* (1910). Flexner did visit the Louisville National Medical College and Citizen's National Hospital in 1909 as well as the University of Louisville Medical Department. What he had to say about Louisville National Medical College was that it was superior in comparison to the University of Louisville program. For instance, for the LNMC program Flexner noted that the entrance requirement was "less than high school education" but for the UofL program he noted that some students were admitted with less than two years of high school. In addition Flexner noted that the LNMC had "nominal" laboratory facilities but that UofL laboratory was "inadequate in appointments and teaching force for the thorough teaching of the fundamental sciences to so large a student body." In addition to these comparisons he credited LNMC with having clinical facilities of 8 beds that were "small and scrupulously clean". In contrast he said of the UofL program, which had a 50 bed hospital to teach in, "the hospital facilities are therefore poor in respect to both quality and extent: unequal to the fair teaching of an even smaller body of students, they are made to suffice for the largest school in the country". He made little other mention of the LNMC program but finished his entry on Kentucky schools with this:

The University of Louisville has a large, scattered plant, unequal to the strain which numbers put on it...there are radical defects to which there is no cure in sight. The classes are unmanageably huge; the laboratories overcrowded and undermanned; clinical facilities, meager at best, broken into bits in order to be distributed among the aggregated faculty. (Flexner, 1910)

By Flexner's report alone, one would expect the University of Louisville program to have been closed, not Louisville National Medical College. What is known is that Flexner focused on the following when making his assessment: admission practice, teaching staff to student ratio, and curriculum. He preferred an "active learning" style to a largely didactic one (Halprin, Perman and Wilson, 2010). Certainly, the Louisville National Medical College must have impressed him. Aside from finding that their admitting practice allowed students who had less than a high school diploma (this is inconsistent with their claims on the 20th Announcement Brochure), he must have been impressed with their German teaching philosophy that encouraged hands on practice. Furthermore, the faculty to student ratio was nearly 1:2. This must have been an indication that the leaders of this school were serious in providing quality education to black physicians. Nonetheless, in 1912, the school closed and no record exists of the reason for this. It is left to speculation and the school's closing has often been credited to the Flexner Report which steered subsequent change in medical school requirements. The assumption being that the school, running on the limited means of tuition from students, was incapable of adapting to the changes that were required after Flexner's Report. However, this seems unlikely when the school had already adapted to increasing demands from the State Board of Medicine. Furthermore, it would certainly not have been Flexner's intent to create a failure for the black medical schools as he was noted to have been in favor of the elevating of black Americans. During one excursion away from home, Flexner wrote these words to his wife, "I was deeply stirred, as I always am, by the splendid and courageous spectacle of a race striving away from centuries of slavery. I could curse the

man or men who put obstacles in their way” (Halprin, et.al., 2010).

We may never know exactly what happened to the Louisville National Medical College but it is unwise to make the assumption that it just shrank up and disappeared due to change in medical school regulation. With the evidence of such perseverance shown in the 20 plus years the school was open, it is unlikely that the leaders of the school just lay down and took defeat. No concrete documentation of this event was found. With the demise of the Louisville National Medical College and its small hospital, Louisville’s black citizen now only had the Red Cross Hospital (which held less than 40 patients) or the black wards of Louisville City Hospital to meet their inpatient needs.

In 1914, City Hospital erected an entire new facility. The pride of the city officials, this enormous public hospital had a bed capacity of 400, and a five acre roof garden. The city officials did take into consideration their role in caring for the city’s black indigent patients when designing the new building and established identical wards for both white and black patients. It had a black male surgical and a white male surgical ward, a black male medical and a white male medical ward, a black female surgical and white female surgical ward, a black female medical and white female medical ward, and a black children’s and white children’s ward. In the first year of opening, the hospital served a total of 5,093 patients: 3,495 white patients and 1,598 black patients. The hospital continued to host its nurse training program and had 82 white nursing students enrolled in 1915. Although the entire nursing staff of the hospital was white, white nurses did not care for black males on the wards. The following demonstrates this fact:

...that white and colored patients were found in the same ward by the grand jury, with white nurses attending both and with both using the same baths...the use of

the pavilion as No. 4, and under the criticism by the grand jury, for white and colored men, was an emergency measure, and done at the special request of the genitourinary and rectal surgeons so that their special cases could be segregated while the hospital was so full, otherwise a number of patients would have been denied admission for lack of beds...In regard to the criticism that white and colored men were in the same ward, this is erroneous and misleading. In this pavilion, as in all the other buildings, the main ward is approached through a wide hall ninety feet long, with a door at the end of the hall connected with the ward and a swing door between. On either side of the hall are small rooms, toilets and bath rooms. The colored men occupied the rooms opening the hall, the white men occupied the larger rooms and wards at the south end of the pavilion. The only means of entrance to the white ward is through this hall. The statement that the white and colored used the same bath room and toilets is entirely incorrect...they had separate toilets and but one bath tub. The colored patients not confined to bed were given their baths on the male surgical colored ward on the third floor, and never used the white men's bath room. The statement to the contrary, when they had direct information that the white and colored men did not use the same bath room, is to say the least surprising.

The statement that white nurses care for the male colored patients is entirely incorrect. There are five colored wards in the hospital, and at present there are 106 colored patients in them. The white nurses on the male colored wards are there as supervisors only, to see that the staff's orders are carried out, keep the charts written up and give medication. The actual care and nursing of

the men is performed by male orderlies on each male ward. We would much prefer that there be no female white nurses in any of the colored wards, and plans are being formulated in collaboration with Miss Patty Semple and Mrs. James B. Speed whereby an affiliation may be had between the City Hospital and the Red Cross Colored Hospital Training School for Nurses. The colored pupil nurses of this hospital would have one year's training at the City Hospital, thus relieving the colored wards of white nurses. (WPA-7-76, 1918)

In 1920, the Courier-Journal published an article entitled "City Hospital: Are Louisville's Sick and Injured Receiving Proper Hospital Care?" (WPA 7-76, 1920). The author, Elwood Stewart, argues that Louisville needs better hospital facilities for a number of cases including "better hospital facilities for negroes and particularly negro children." Also, he estimated that Louisville needed approximately 1,500 hospital beds instead of the total 1,030 that it had at the time of his writing. He states "the recent survey made by the Jefferson County Medical Association indicates that ordinarily only three-fourths of Louisville's hospital capacity is in use. One-fifth of Louisville's population is negroes, who lack hospital facilities and also dislike going to hospitals" (Courier-Journal, April 12, 1920). The reason that black Louisvillian's disliked going to hospitals is not stated.

What is known is that some black residents had a superstitious aversion to the hospital ambulance. The following excerpt is from a Courier Journal article:

Negroes employed at the garage absolutely refuse to enter the ambulance and one asked for his pay when it was insisted that he go inside and clean the interior. They will clean the outside, polish the brass and do any work that is needed on the

exterior, but the line is drawn at passing through the door. The cleaning can be done only during the day time also, as when night falls the negroes fight shy of the ambulance as they would a haunted house. (WPA files, 10-58, ca. 1914)

It is not known why there was a fear, if there were indeed a fear, of the back of an ambulance. Could it be that there was some association with death? Fear promulgated by the white community for some purpose perhaps?

Interestingly, there was no indication in the health related archival material that World War I had any impact on the health needs or state of Louisville's citizens. There is no mention of the war in any of the archival material covered. However, at the close of the war in 1918, Louisville, like much of the world, was hit with an epidemic of the Spanish Flu. The first case was reported on September 27, 1918 and lasted through March 31, 1919. Its hardest hit category was young children 0-4 years of age. Black children had double the death rate of white children at 65 to 31 deaths. An ever-increasing in strength health department was in force by this time and was divided into an Eastern District, a Western District and a Colored District. Presumably the two black physicians mentioned earlier were assigned to the "Colored District". The first black public health nurse, Lutie B. Reid, came to the health department in 1919.

Ms. Reid apparently began her work as a school nurse with the Louisville Health Department in 1919. It is not known where she received her nursing diploma but a census record assessment shows her to be a native of Louisville. She may have received her nursing diploma from the Red Cross Hospital, which did have a nurses training

program running at this time. The health department sent nurses to the Louisville community schools to assess the health status of the students and assure that proper follow-up occur for deviations in health. In 1919 the nurses identified a troublesome prevalence of trachoma, an infection of the eye caused by chlamydia trachomatis bacteria which can lead to blindness, among large numbers of children. The nurses made sure these children (white and black) received proper treatment and even assessed the families to identify other cases in the child's homes (A History of Health in Louisville, ca. 1939, Louisville Health Department Collection). The public health nurse, especially in the black community, would prove to be indispensable. Image 5 gives an example of the work that the black health nurses were involved in.



Dr. P. R. Peters, School Inspector

Clinic in a Colored School.

Lattie Reid, Nurse.

Image 5: Clinic in a Colored School, Kentucky State Medical Association 1920-1921

Annual Report, page 55.

1920-1940 The black community gets a health department clinic

Nationally, the country began to slip into an economic depression during this time. The Great Depression reached worldwide and lasted from 1929 until 1942, with the nation's gross domestic product (GDP) dropping significantly followed by a severe decrease in employment. Americans, white and black, struggled to put food on the table. This surely placed further strain on Louisville's black community. It was also in this era, as people in and out of government began to search for solutions to the Depression, that black civil rights protest became more numerous, along with unemployment marches (Encyclopedia Britannica, 2013).

Up to this point in history, the black population in Louisville had approximately forty physicians in practice, a hospital with approximately 38 beds (10 for children) and a small public health representation in the Louisville Health Department (one doctor and one nurse). Black patients who had no means to pay for hospital care were eligible for indigent care at the City Hospital (approximately 200 beds) or one of the City Hospital's free clinics. A list of white hospitals and bed capacity in 1923 demonstrate the large disparity in health care availability to black patients of this time: St. Joseph's Infirmary, 85 beds; St. Anthony's, 85 beds; Jewish Hospital, 64 beds; Norton Infirmary, 110 beds; St. Mary and Elizabeth, 75 beds; Deaconnes Hospital, 125 beds. Around this time, Kentucky Baptist was finishing its hospital to provide another 130 beds to the white community (WPA 10-60, 1923). It is evident that the quantity of health care facilities available to Louisville's black community was far inferior to that of the white community in the early 1920's.

By the 1920's the facilities of the City Hospital appeared to have been rampantly used and had already begun to show wear. Furthermore, the facilities were no longer sufficient to provide for the growing number of patients seeking care, black and white. Looking for ways to expand, city officials considered buying the Deaconess Hospital for \$200,000 and converting it into a hospital for black patients, which would lead to more space for white patients at City Hospital. It appears that there was some involvement by local black physicians on this feasibility study. The leaders hoped to create a hospital that "would be to give the colored people a hospital of their own, which would care solely for colored patients, with colored nurses and colored physicians in attendance" (WPA 10-60, 1926). The study, conducted by the Community Chest Health Council, revealed that the amount of beds the city would gain from purchasing the hospital, 65, would not be enough to justify such a transition. Many on the committee, and several of the black physicians, were surprised to learn that the City Hospital reserved half of its beds (206) for the black patients, so a new facility would have to accommodate at least that number to suffice. That the document mentions surprise on the part of white and black physicians in being informed of the amount of beds reserved for black patients at the City Hospital begs the question: Were these beds merely a fictional figure and in actuality less beds were being reserved for black patients? There is no evidence to support an answer to that question. Ultimately it was decided that the city would forego the purchase of Deaconess Hospital and City Hospital would be expanded. The Health Council recommended the following:

1. That instead of building a separate unit for Negro patients, the present City Hospital be requested to undertake the training of colored nurses on the

colored wards and to provide housing and class-rooms for them.

2. That the University School of Medicine be requested to admit dispensary service for three months during the summer the eligible colored physicians desiring such service. The Council is convinced that the building up of Negro hospitals manned by Negro physicians in other cities has been a matter of slow growth and suggests that service during the summer months would afford a beginning here in Louisville that would give an opportunity to the Negro physicians to show their willingness to give service and take the necessary responsibility which comes with staff appointment. (Community Chest, 1926).

The black physicians were allowed to gain experience in the City Hospital dispensary with the black patients only that following summer. The white leaders felt as though their allowing the black physicians to practice in the city dispensary during the summer months (while the white medical residents were not present) was an opportunity for the black physicians to “show their serious intentions to take advantage of clinical opportunities”. This in turn, it was hypothesized, would lead to a wider acceptance by the community at large of the city establishing a black hospital for the indigent. Local black physician Dr. John Walls expressed his disappointment in the decision not to establish the hospital but conceded to the plan for black doctors to train in the dispensary during the summer as “a beginning” (Community Chest, 1927). There is no record that this ever happened again. There is also no indication that the recommendation to assist with nurse training of black students ever occurred either.

The feasibility study for a proposed “Negro” hospital also gave the following

description of Red Cross Hospital:

The hospital provisions for Negroes consist of 206 beds at the City Hospital and 38 beds at the Red Cross Sanitarium, a total of 244 beds. For the Negro population of 46,800 (as given in the census of December, 1925) this affords a ratio of 5 plus beds per thousand, a ratio usually considered adequate for the general population. The hospital opportunities for the colored physicians of the city are limited to the Red Cross Sanitarium.

The Red Cross Sanitarium is a fairly modern brick building conducted for hospital purposes. The hospital has no staff, both white and colored physicians attend the patients. The hospital receives a State appropriation of five thousand (\$5,000.00) annually for the care of sick colored children from the state at large. Colored crippled children are referred to it by the State Crippled Children's Commission. It lacks any facilities for the care of obstetrical cases, having no delivery room. Patients are delivered in their bed rooms.

The hospital serves but two meals a day—breakfast between 8:30 and 9:00 A.M., and dinner at 3:00 P.M.

The charges for rooms are moderate, ranging from \$10.50 to \$12.50 a week, and the semi-private ward accommodations are rated at \$10.00 week.

The hospital conducts a training school for colored nurses. At the present time twelve students are enrolled. The superintendent is the only graduate nurse. The operating room work is assigned to an undergraduate senior. The course of training covers three years. Lectures are given to the nurses by the colored physicians. All other teaching is given by the superintendent. More adequate

supervision should be provided for the students.

And regarding black physicians:

According to Mr. Ragland of the local Urban League there are 44 Negro physicians in the city, 40 of whom are in active practice. In the directory of the American Medical Association for 1925, 36 Negro physicians are listed. The ratio of Negro physicians is one to each 1,170 of the Negro population. There are 553 white physicians listed, or one to each 468 of the white population. (Community Chest, 1926)

The above entry demonstrates the disparity that existed for black residents in Louisville seeking medical care in the mid-1920's. The ratio of black physicians to black patients was twice as high as in the white population. Furthermore, black nurses and physicians had an inadequate field for learning, despite Louisville being the only city with a black hospital in the state. It was not for lack of effort on the part of Red Cross Hospital leaders, however. A February 1925 Courier-Journal article describes the "relentless work and affectionate sacrifice on the part of the board of managers and the advisory board" as central to the hospital's success (Lux, 2009). Bake sales, rummage sales and Christmas bazaars were only a few of the measures the Women's Auxiliary Board of the Red Cross Hospital used to raise funds to pay off the first building and make progress on paying off the second (which had been acquired to increase the bed accommodation). Those who were not able to contribute financially contributed through volunteer work. One individual did laundry to help out, another washed windows, showing support from the black community at large. The hospital also accepted charitable gifts from both affluent blacks and whites. The hospital took in more charity

cases than paying cases, however, and wise business acumen was needed to keep the hospital afloat. Afloat it stayed, however, and for a little while longer it continued to run its nursing school. By 1925 the school had graduated twenty-six students from its program. In 1932 a nurse's dormitory was built. Unfortunately, the success of the nursing program ran out. Unable to receive accreditation (the exact reason unknown) the nursing school program was forced to close in 1933 (Lux, 2009). The closing of the Red Cross nurses training program left the city of Louisville without a training school for black women (or men) to become nurses. No other nursing program would accept black students until the 1950s. Image 6 shows one Red Cross Hospital graduate from the late 1930s, Laura Dooley.



Image 6: Laura Dooley, Graduate of Red Cross Hospital Nursing School, by permission of Flora Ponder

The same spirit that benefited the Red Cross Hospital was not present with the

Colored Orphans Home, however, and in 1926 a local organization called the Community Chest (which later would combine with several other organizations to form what is now known as the United Way) created a committee to assess the home. The report was not good. The committee found that the required practice of immediate physical examination and quarantine for new arrivals was not being followed, and two children had spread whooping cough as a result. Also, it was found that the children were served inadequate meals which were void of leafy green vegetables or milk. There were inadequate hygiene materials and practices as the children were found to have either a towel, or a washcloth, but never both and were forced to share these supplies with one another. Scabies and pink eye had been a problem amongst the children at one point. In addition to these things it was discovered that the children did not have enough undergarments to change on a regular basis. Bedwetting was an issue for some of the children and it was uncovered that they were being disciplined in a “cruel and ineffective” manner for this offense. Furthermore, some of the children had been bitten by rats and the regular roaming of rodents at night was causing the children a lack of sleep (Community Chest Colored Orphan’s Home Report, 1926). It was decided that only twelve of the thirty resident children actually needed the care and the other eighteen children were sent to relatives. The twelve who needed an institution were moved to the Louisville and Jefferson County Children’s Home (Community Chest, Report of the Secretary, 1926).

The Community Chest Health Council provided considerable insight into the attitudes of whites toward black residents during these two decades. Its officers included Dr. Irvin Abell, Dr. Morris Flexner, and Dr. Stuart Graves. Dr. Graves was the Dean of the University of Louisville School of Medicine from 1923-1929. He was listed as the

“Negro Health” committee officer for the Community Chest Health Council. An article written by Dr. Graves in 1916 regarding syphilis testing had the following to say:

Now let us step back and consider these cases with broad perspective. In the first place, taking for granted that an unquestionably skillful and persistent effort is always made in a public hospital to obtain a perfect history, recollect that 87 per cent of these patients in this class were negroes, almost equally divided as to sex, and that many of them came from the lowest and most unfortunate walks of life. The prevalence of syphilis among negroes is notorious. Their stories in hospital wards are notoriously unreliable. The average negro may not mean to lie; he simply does not know how to tell the truth—and if he is truthful he may not know he has had syphilis. (Community Chest, 1916)

It is not clear how long the Community Chest Health Council functioned but there exists material primarily from the 1920s to the early 1930s in archives. One thing that the organization did was partner with other organizations in creating events for the “Negro Health Week”, a nationwide health event designed to improve health education in the black community. The first observation of this week long event in Louisville took place in 1923. Until the Community Chest Health Council became involved it had been an impossible undertaking for the black leaders. The event was organized by efforts of the Community Chest, along with the State Y.M.C.A., the Urban League, the Inter-Racial Commission, the State Board of Health, and in cooperation with the local churches, schools, women’s clubs and civic organizations. Prizes were offered to schools with the best essays or posters regarding matters such as, “What to do with a backyard”, “How to

keep a front yard clean”, “What to do with the rubbish around the yard”, “How to keep a body clean”, “The value of the toothbrush” and “How to keep a house clean”. The idea of a Negro Health Week initiated in 1915 by Tuskegee Institute President Booker T. Washington.

For the most part, the Negro Health Week events garnered support from the black community; however, in 1926 there appeared to be some irritation on the part of the black physicians in the city. In a letter to Dr. Graves, the executive secretary, Mary L. Hicks, comments that she may know “the reason for the Negro physicians failing to cooperate this year as they did last. It seems that at least some of them feel Doctor Bond did not take them into consideration when planning the series of lectures and has not kept closely in touch with the colored physicians since first presenting the plans for Negro Health Week at the medical societies” (Community Chest, Health Council letter, April 9, 1926). Rev. Dr. James Bond was a Kentucky native, educated at Berea and Oberlin Colleges and a former “Colored” Y.M.C.A. leader. George C. Wright’s characterization of Dr. Bond is as follows:

His philosophy was that blacks should press for their rights for an education, for decent jobs, and for other rights as taxpayers while being prepared to accept less than they desired. He believed that it was far better for blacks to receive only half of their goal and to have whites and blacks on good terms, than for blacks to be successful in achieving certain demands at the price of increased white resentment.

How could Bond call himself an advocate of black rights and yet be so willing to compromise his positions? When looking at his life it is understandable

why he consistently advocated such an approach. Bond barely made a living pastoring churches. The only economic security he enjoyed was as director of the Kentucky CIC (Commission on Inter-racial Cooperation), a position that encouraged, if not demanded, Bond to take a more sanguine view of race relations. So white Louisvilleans still controlled a segment of the black leadership. (Wright, 1985, p.208)

Bond, similar to Booker T. Washington, had less than an aggressive approach at asserting the rights and needs of the black community. Could it be that the black physicians who opposed the Negro Health Week topics planned by Bond felt that the topics were paternalistic in some way? Some of the lecture topics to be given to black physicians were: Drug Addiction, Prevention of Tuberculosis, Prevention of Goitre, Mental Hygiene of Childhood, Prenatal Care and Treatment of Syphilis in Children during Prenatal and Postnatal Periods (Community Chest Announcement, ca. 1926). It is not clear if these physicians solely resented not being included in the decision-making or if they found the topics distasteful. Nonetheless, what it does reveal is that “Negro Health Week” may not have been widely received in the black community.

Other artifacts found in the archives of the Community Chest attest to the racial prejudices of Dr. Graves, the “Negro Health Officer” and his cohorts. Meeting minutes from April ca. 1926 discuss the wording of a report that had been written and was to be circulated (presumably about Negro Health Week) and apparently Dr. Graves, the “Negro” Health Committee chair had a concern with the wording of the document:

“Considerable time was given to the wording of the Report in the section on Hospitalization of the Negro and the advisability of omitting the sentence mentioning the City Hospital. Dr. Graves urging the omission of this sentence as its being retained in the report would result in embarrassment to the Hospital and Medical School and would not assist in the general public program relating to the Negro Health.” (Community Chest, ca. 1926)

It is interesting to note that the white physicians were embarrassed to let it be known that white doctors were caring for black patients at the City Hospital.

Another indicator of the assumptions by the Louisville white health care professionals about black citizens can be interpreted from another piece of archive material from the Community Chest. A letter written by the secretary, Mary L. Hicks, to Dr. Graves states the following:

“My dear Doctor Graves,

I wish to call your attention to the following article which will be of interest to you.

Hoffman, Frederick L. The Negro Health Problem. Opportunity , April 1926 p.119

Yours very truly,

Mary L. Hicks (Community Chest, 1926)

The article was most revealing. It was written in a manner that appeared to show concern for the health needs of black people, but stereotypical undertones (and some brazen statements) dominated the article:

Before I proceed with my discussion of more specific health conditions, I wish to

draw attention to the present Negro birth rate and problems which arise out of more or less abnormal fecundity. Previous to emancipation, the Negro population was fertile, and the women were not only frequent, but broadly speaking, wholesome breeders in that accident in pregnancy were relatively rare. For the Negro population at this time it is doubtful if the excess is as much as 10 per 1000 while probably it is not more than 5 or 6 (births per 1000 persons). The lower fecundity of the Negro at the present time compared with pre-war conditions is unquestionably the direct result of the widespread habits of birth control and artificially induced abortions. Several factors in conjunction with this practice which further complicate a serious situation. The still birth rate of the Negro is 7.4% of all live births against 3.6% of the white population. Here, then, is a tremendous waste of human life largely the consequence of widespread habits of attempts at birth control and attempts at artificial if not criminal abortions. Another complicating factor is the high rate of illegitimacy which among the Negro population is 12.3% of all living births against 1.4% of the white population. Illegitimate births coincide in a large measure with widespread venereal infections which among the Negro population are unquestionably decidedly more common than among the whites. Unfortunately information on this subject is not easily obtainable but all the special investigations which have been made have conclusively shown a very much greater degree of frequency of venereal infections among the Negroes than among the whites. As long as this condition continues, the race cannot possibly come to make the progress of which it is capable and which is reasonably within reach. (Hoffman, 1926)

This portion of the article demonstrates the assumption made by white health care providers that black people were sexually immoral. Also, it alludes to the idea that they had preponderance toward unethical and illegal behavior (abortions in this case). Similar sentiments by white leaders were noted just after the Civil War when the Freedmen's Bureau officer spoke of the high rate of "taking up" among the freed slaves.

The Community Chest appeared to work very closely with the Louisville Health Department. Many changes were occurring within the health department that likely had a positive impact on the inhabitants of Louisville, no less so the black residents. Annually, the Health Department participated in a "Health Conservation Contest" hosted by the American Public Health Association. In connection with the 1935 contest, Louisville was awarded a complimentary appraisal of its health activities and needs. Field director of the American Public Health Association rated Louisville 737 out of a possible 1000 points. He strongly urged the city to "remove the Health Department from politics" and mentioned several areas that pertained to the health of the city's black population that were in need of attention. First of all, he felt that the hospital bed allotment for the black community was far inadequate. He recommended that the city establish a minimum of 180 more beds at the City Hospital exclusively for black patients. He further recommended that the 180 bed pavilion be "under the general supervision of the hospital but to be directly supervised and operated by Negro physicians and nurses" as it was known that in order for black physicians to improve their practice they needed "the opportunity of caring for the patients in the hospital as well as in the home". In response to this recommendation, the mayor appointed a commission to make a special study of

the feasibility of such an addition. The commission decided that it was not economically feasible to build a pavilion to house additional black patients at that time and promised the black physicians could train on the black hospital wards in the summer months when the white medical students were not using it (Louisville Health Department Report, 1936). This incidence brings to light the attitudes that white health care providers had towards black patients in relation to personal gain. On one hand you have a physician saying that making it publicly known that white physicians cared for black patients at the city hospital is embarrassing, and on the other hand you have white physicians not willing to give up their black patients when it benefits them for the purpose of learning. The notion of the black patient as a specimen to be learned from will be discussed later.

Dr. Buck also recommended that there be more beds available at the tuberculosis hospital (Waverly Hills Sanatorium) for black patients. Tuberculosis had a greater mortality impact on the black community than it did on the white community with over twice as many black Louisvillians dying from the disease than whites. He noted that black adults were having to wait for beds at Waverly Hills due to an overflow of patients who were chronic and needed custodial care but had no place to go. He suggested that a custodial care facility for these patients be added as well (Buck, 1935). There had just been an additional hospital for the sole treatment of black patients opened at Waverly Hills in 1932 (History of Waverly Hills, undated document). There is no evidence that the city officials addressed Dr. Buck's recommendations, however.

Dr. Buck did have some words of praise for some of the Louisville Health Department efforts, however. Although he felt the nursing staff inadequate for the size of the city, he recognized that the nurses in the department were carrying out tremendous

work teaching the public about tuberculosis and identifying new cases. Also, the nurses assigned to the local schools were identifying health problems among kindergartners, fourth graders and those entering junior high school and seeing that these were followed up by either a private physician or a free city dispensary. He urged the department to hire more nurses (black and white) and increase their salaries (Buck, 1935).

The role of the black nurse in the delivery of health services to the black community was very important at this time. At least two black nurses had been carrying out the work of school children assessments up to this point and in September of 1937 a health center was opened on 920 West Chestnut Street for the black community with six black nurses on its staff. The center was called the “Central Health Center”. Dr. C. M. Young Jr. was hired as director of the facility. The nurses, supervised by Louisville’s first black public health nurse, Lutie B. Reid, carried out the work of maternal health education, communicable disease control, school health assessments, infant and pre-school conferences and sanitation. The clinic served an area from 6th to 24th Street and from Market to Broadway, black residents only. There were nineteen black schools covered in the service of this health center and health assessments and vaccinations for diphtheria and small pox administered at these. In addition to all these services, the city transferred all of its syphilis clinic patients (black) to this facility for treatment. Syphilis was proving to be a menace to the black community (the white community also). Unlike the white community, however, in the black community cases were not being identified until the disease was at a much later stage. The nurses worked to educate the community about the disease, identify cases that needed to be treated, and administer treatment which, at that time, was a very lengthy affair. The nurses also monitored for follow-up,

keeping accurate track of those patients who needed treatment and ensuring that treatment was not interrupted. The nurses were very active in the affairs of “Negro Health Week”. They gave talks in the schools and churches as well as demonstrations on baby care at the Center (Louisville Health Department Annual Report, 1938). Image 7 gives an example of this work, displaying a late 1930s prenatal clinic at the only black health department clinic Beecher Terrace. Image 8 displays the entire Louisville Health Department staff in the early 1940s. There are several black nurses in the photo, but only Lutie B. Reid (the first black nurse in the department) stands in front among the white staff.



Image 7: Beecher Terrace Prenatal Class, ca. 1940 (UofL Digital Archives Collection with permission)



Image 8: Louisville and Jefferson County Public Health Nurses, 1943, from the private collection of Flora Ponder. (Lutie B. Reid, first black public health nurse employed by Louisville Health Department stands in foreground with white health care providers)

A discussion of this era would not be complete without discussing the impact of the Great Depression on health care. As more people, black and white, found themselves unemployed and income levels dropped, more people sought public health institutions for their health care needs and the private health care institutions saw a decline in patronage (Stevens, 1989). This trend was true in Louisville and the City Hospital saw an increase in numbers, especially from individuals who lived outside the city limits. The policy for eligibility of care at the City Hospital was that an individual had to reside in the state for one year and the city for six months prior to admission. A study of individuals who attended the free clinics from 1929-1938 revealed that 52% were white and 48% were

black. Black residents were a little more likely to be unemployed. Of those numbers 27% of white men were unemployed and 30% of black men were unemployed. Only 18% of white women were considered unemployed (31% were listed as housewives) and 23% of black women were unemployed (24% listed as housewives). Economic concerns led to the merging of the Jefferson County Health Department with the Louisville Health Department in 1938.

Another event of this era was the 1937 flood in Louisville. The most severe flooding occurred west of downtown with many individuals being trapped in their homes. The Louisville Health Department began to set up typhoid vaccines at several locations close to the high water when it was predicted that the waters would begin to rise. Once the flooding had fully enveloped the western section of the city, the Health Department set up “Refugee Stations” on high ground in the West End and in the Central area. Doctors and nurses were recruited from the Jefferson County Medical Association and the black alternative of that, the Falls City Medical Society. “Emergency Hospitals” were established throughout the city and it appears that these were segregated. Three of the fifteen hospitals established for this disaster were deemed for black patients. One at Atherton High School (for 150 patients), one at the Belknap School (10 beds) and an extension of City Hospital housed in the Longfellow School with an unspecified amount of beds. Apparently, the hospital at Atherton High School was a mobile hospital set up by the U.S. Army Medical Corps (Louisville Health Department Annual Report, 1937).

1940s Seeds of Change

By the 1940s the world was at war. The United States joined that war in 1941. World War II created a change in the tide of industry. Across the Midwest and Northern

regions, war industry jobs quickly became plentiful. In response, many blacks moved to these regions' industrial centers to seek employment. The American involvement in the war against fascism in Europe struck a note with blacks at home. The fight for Civil Rights began to take root as black Americans demanded their fair share of defense jobs (Fosl, 2002).

The decade of the 1940s brought some substantial growth to the Red Cross Hospital. In a 1939 accreditation visit by four board members of the American College of Surgeons there is noted to be a bed capacity of 60 beds, but only 40 of those readily available. Yearly, the hospital treated approximately 15 obstetric cases, 50 crippled children (the hospital received \$4000 from the Kentucky Crippled Children's Commission) and 300 other cases. The surgeon's board made multiple suggestions for improvements and the hospital board responded by soliciting help from the community. The hospital was the recipient of a Rosenwald grant of \$16,000. However, a 1942 Courier-Journal article urges the community not to assume that the financial need has been met. Of the grant money, \$10,000 was to be used for hospital rehabilitation and the other \$6,000 to improve lab equipment and hire an X-ray technician. Mrs. Charles Horner, a member of the hospital's executive committee, stated "as valuable and as welcome as these grants are, they won't pay the butcher, the baker and the candlestick maker---and other operating expenses." She commented that the hospital creditors had been kind enough to allow the bills to run over "a long period of time". The hospital leaders were asking for help from all members of the community (Courier-Journal, February 8, 1942).

Also in 1942, the hospital was awarded a \$38,260 allotment from the Federal

Works Agency. Then in 1943, upon the death of the hospital's biggest white supporter, Ms. Hattie B. Speed, the hospital received two lots through her will. This let the hospital be expanded from 1438 and 1439 Shelby Street to 1438-1442 Shelby Street. The expansion allowed for 10 ward rooms and a nurses home. Plans were underway to re-start a nursing program as well. Then, in 1945, hospital leaders kicked off a drive to raise an additional \$50,000 espousing the need to secure an incubator for premature babies, a fracture frame, a universal operating table, oxygen equipment, surgical instruments, laboratory and multi-beam operating room light. A February 9, 1945 Courier Journal photo shows a gentleman in a hospital bed with a crude wooden "fracture frame", held up at the foot by a wooden chair, as representation of the type of struggles the hospital staff contended with in delivering care to their patients (Courier-Journal, February 9, 1945).

White support could be characterized as self-regarding empathy. A *Courier-Journal* article written to boost white community support chastises the white community for not having been as involved and reminds them that if they want to maintain segregated care, they should be compelled to support the program.

"The White People Ought to Help"

That the Red Cross Hospital has raised only \$8,500 of its \$50,000 goal in the first twelve days of a city-wide drive for funds is a reproach, not to the Negro minority, which is giving to the limit of its ability, but to the unconcern of Louisville's white population. As a community we adhere to the Southern pattern of segregated facilities and as a result no Negro who wishes private hospital care can obtain it outside of the small, inadequately equipped and financed Red Cross Hospital. Nor can Negro physicians, nurses and internes practice freely among

their own people of reel encouraged to settle in Louisville. (Courier-Journal, February 27, 1945)

In 1947, in the postwar economic boom, construction began on a new children's ward at the hospital which would increase the hospital's ability to care for an additional 30 children (Courier-Journal, September 23, 1947). Within a year, the hospital leaders were seeking more funding. This time their goal was a whopping \$450,000, one-third of which would be covered by the Hill-Burton Act funds. The Hill-Burton Act, passed in 1946, was a federal law that designed to provide grants and loans to the nation's hospitals and thereby improve the quality of care. The federal goal was to obtain a representation of approximately 4.5 beds for every 1,000 people across the nation (Wikipedia.com, 2013). The hospital board appointed a local white businessman, J. Edward Hardy, to chair the campaign. The money to be raised would increase the bed capacity from 60 to 100, add a delivery room for obstetric patients, modernize the operating room and laboratory and increase the number of nursing students that the hospital could accommodate. The hospital had met requirements by the American Medical Society and the State Board of Nurse Examiners to re-establish nurses training. The nursing students would take a year of course work at the Louisville Municipal College and then the following two years at the Red Cross Hospital and the City Hospital. This was to be the first time black nursing students would receive training at the City Hospital and they would be limited to training on just the black wards (Courier-Journal, September 12, 1948).

In addition to training more nurses, the hospital leaders hoped to attract more

physicians to the city. The following excerpt from a Courier Journal article reveals the intensity of the problem:

The lack of hospital facilities has seriously handicapped the practice of medicine among Negroes. The average age of Negro doctors in Kentucky today is over fifty. For twenty years not a single young Negro physician settled in Louisville: but since 1945, when the Red Cross Hospital was modernized, six have come here. With improved facilities for good professional work, more will come. (Courier-Journal, ca. September 1948 found in the Red Cross Hospital Collection at the University of Louisville UARC).

The white community response to the Red Cross Hospital modernization funds drive is revealing. Again, white support exhibits itself in self-regarding empathy. In a Courier-Journal article, ca. late September 1948, the journalist remarks:

In a beautifully illustrated brochure especially prepared for the campaign, it is graphically pointed out that infection respects no color line, no economic line, no class line. You cannot expose 18 per cent (Negro) of the population of any community and keep the other 82 per cent (white) safe. Negroes infiltrate every part of Louisville... There is no thing as a Negro health problem. There is only a public health problem, which is all one, and any point that is left unguarded is a threat to the whole. (Courier-Journal, ca. September 1948)

Another article gives insight into the attitudes of Louisville's white health care providers:

Dr. G.G. Altman, member of active medical staff, Red Cross Hospital, and

American College of Surgeons, said at the kickoff dinner meeting of campaign workers Monday night:

The hospital has emerged from the sick boarding house to a modern hospital. It still has far to go, but the spirit is here, the willingness is here and the quality of service is here. The physical aspects, building, operating rooms and other necessities are the deficient things...

Of course I am fully aware of the so-called racial line in the south of which we in Louisville are considered a part. However this may be, the fact remains that sometimes you of the Negro race are not too wise. Too much thought and effort and ill will is given to the society for the advancement of colored peoples with too little thought and perhaps even, too, realization of the facts as they are.

He said that the fact must be considered that Red Cross is a colored institution, for its people and for use by its doctors—white doctors and others are there by courtesy. The eminent surgeon explained he was aware of the occurrences of the past several months when St. Joseph Catholic Hospital, a white institution, admitted Negroes. But this is not progress, he said, it is acceptance on orders. It must for the time being also be known to you that sooner or later wards will be set aside for these cases, yes, call it what you will, but segregation it is.

The doctor said now the Negro is being given the opportunity, through the campaign, to obviate this need. The doctors are here and others will come, he said. Nursing is had and a training school is in process. Recognition in part of the American College is had, and with better facilities this will in time be

complete. Our need is building enlargement and room for work, he declared.
(Red Cross Hospital Scrapbook, ca. 1948)

Apparently, Dr. Altman felt that the issue of segregation was so deeply imbedded that it would not be changed in the foreseeable future. The NAACP and black leaders had been agitating against segregation, and the momentum had only escalated after the Second World War (K'Meyer, 2009). Dr. Altman seemed to discourage the hopefulness that some of the black community, and black medical professionals, may have had in the act of St. Joseph's Catholic Hospital admitting a few black patients as indicative of change from segregated care. This newspaper article described the first time in the history of the city that a white, private health institution, accepted and treated black patients. The fact that the doctor describes the incident as just "acceptance on orders" will prove to be revealing of the changes that will come about in the 1950's and 1960's within the city's health care system. One other thing we can glean from the words of this white health professional is his apparent disdain for the "society of the advancement of colored people" (could he be referring to the National Association for the Advancement of Colored People, NAACP?) when he says that sometimes black individuals are "not too wise" for putting so much emphasis on making change (from segregation) and not just accepting the "facts as they are".

The campaign to raise \$450,000 was successful. In fact the hospital raised just over the amount sought and in December 1948 announced that they would be building a new four-story building on their property which they would name after the former Louisville mayor, Alexander Heyburn, who had been in favor of equal accommodations

at the Jefferson County Children's home years earlier. The newest building would open the following decade.

With America at War in 1941, things changed for the City Hospital during this time. It began to see a decline in medical and nursing staff, as the military claimed ever increasing numbers of these professionals. The military began to pay for nursing student education expenses and a cadet nurse program was conducted at the hospital throughout the war years. Unfortunately, the nursing program (including the cadet nurse program) was closed to black nursing students. There appeared to be no notable incidences in regard to the care of black patients during this time, however (Louisville General Hospital Nursing School Collection, Kornhauser Library).

Waverly Hills Tuberculosis Sanatorium did add approximately 65 beds to its facility for black patients. By 1945 it had 185 beds available for black patients in the segregated hospital (Louisville and Jefferson County Health Department Annual Report, 1945) By now, the city and county health departments had merged and so the expense of this new facility was shared. The county tuberculosis facility, Hazelwood Sanatorium, was closed to black patients. Tuberculosis continued to be a leading cause of death among black residents and they made up 40-45% of the city death rate every year (Louisville and Jefferson County Health Department, 1942).

Another serious problem in the city was the rate of venereal disease. With the increased presence of military members in the city during the war years, the problem was particularly profound. A "vice squad" was implemented to identify individuals prostituting or soliciting the service of prostitutes. The health department was concerned because "with the large concentration of military personnel and the development of war

industries in the area, new problems were added to the old ones. It is was inevitable that there should be an influx of women, including not only prostitutes looking for “easy pickings”, but war workers, stranded army wives, and young girls looking for excitement”. The “vice squad” picked up 2,099 women in 1944 on “moral charges”. It only arrested 692 men on the same charge. The health department claimed that the biggest problem was the “chippie”, or the girl looking for a good time. Interestingly, the department notes that in a 1945 study it was found that “it is not easy for a white soldier to contact a professional prostitute here; there are many “chippies” easy to pick up. The Negro soldier has no difficulty in contacting either a prostitute or “chippie.”

Furthermore, the Department of Health report said the following about the prevalence of venereal disease in the black community:

The slum area is the focal spot in the community for tuberculosis, diseases of infancy, venereal diseases. It is the breeding ground for crime, juvenile delinquency and prostitution. For this reason, it is not surprising that Negroes, who have a high proportion of their population in slums, have a high incidence of venereal disease, just as they have a high tuberculosis and infant mortality rate. Louisville has built three housing projects for its Negro population, but these do not solve the problems of economic insecurity, low income, and absence of cultural opportunities. And until some of these problems are corrected high mortality and morbidity rates will continue. (Louisville Health Department, 1945)

To deal with the problem of venereal disease, the Health Department established two new “rapid cure” hospitals. Previously, the treatment for syphilis took eighteen

months and gonorrhea treatment took several weeks. The rapid treatment would shorten that to eight days and two days, respectively. This timely treatment could allow the patient to be kept in hospital until treatment was completed, thereby avoiding the frequent problem of interrupted treatment. The hospitals, treatment and even transportation to and from the facilities were to be free of charge. One facility was at the fairgrounds and the second at General Hospital (formerly City Hospital). Although the treatment was available free of charge to anyone, regardless of race, it is not clear if both facilities took both black and white patients or just one (Courier-Journal, September 17, 1944 found in the Louisville Health Department Collection at KLHC).

The Louisville and Jefferson County Health Department continued to have just one health center dedicated to the care of the black community during the 1940's. The Central Health Center, which had been located in the federally funded Beecher-Terrace Housing project since 1941, was administering to the health needs of approximately 65,000 black residents by this time. Central Health Center nurses did the same work that the city's other health center's nurses were performing but had some extra duties as well. For instance, in addition to pre- and post- natal clinics, child health conferences, and school nursing duties, the Central Health nurses also made follow-up home visits to the patient in their district that were being treated for syphilis and they performed all the tuberculosis screening for the black community as well (Louisville and Jefferson County Health Department Annual Report, 1945).

Norma Mason-Stikes, who would later be the first black nurse employed at Our Lady of Peace Hospital, was a little girl at this time and was dreaming of becoming a nurse. She remembers public health nurse Lutie B. Reid coming into her neighborhood

“to see someone’s baby or something and she was just so neat and I would go over there just to watch what she was doing.” According to Stikes, the black public health nurses were well respected and well received within the black community. This is corroborated by a statement made by Flora Ponder who was a nursing student in 1954, Flora Ponder recalls that the black students were assigned to the Beecher Terrace location (Central Health Center) and she especially enjoyed working with Ms. Sophia Fox Smith, a nurse who was assigned to the outlying territories such as Berrytown and Newburg. She describes how Ms. Smith would arrive on “clinic days” in her car and “when she turned onto the lane, she would start honking. Folks would come out, happy to see her. They would be dressed in their best clothes. She would set up a picnic table and they would come”.

The decade of the 1940s would close out much as it started, at least on the surface. The health care system remained predominately segregated. There were in existence several private, whites-only hospitals, one public, indigent hospital and one private black hospital. All of that would change in the next decade and beyond. Segregation was the norm. White health care providers still held stereotypes as to the cleanliness, morality and ethical behavior of blacks. White health care providers included black residents in care where they were obligated to do so (as in the case of the Public Health Department) and where it was in the white community’s best interest to do so.

Part II

What healthcare was available to Louisville's black community after integration of the healthcare system?

Paternalistic Opportunism

Introduction

The archival material reveals that the act of integration within the health care system actually began to occur in the late 1940s, which is over a decade before the Civil Rights Act of 1964. This transition period showed a marked change in the attitudes of white health care providers toward black Louisvillians, at least on the surface. The attitudes of these white health professionals and community leaders at this time are best described as paternalistic opportunism. In this instance white health care providers continued to feel a level of authority over black residents but were now faced with an opportunity to enhance their own situation by including black patients within the white health care system. While old stereotypes and assumptions regarding black people surely did not just disappear, they do literally disappear from the archival material in the late 1950s to the early 1960s. In fact, it is around this time point that the terms “negro” and “colored” are replaced with “non-white” in comparison to white. It is likely that this is the point in which the overt assertion of these attitudes toward black residents, by white health care leaders, becomes socially unacceptable. It is very unlikely that they assumptions just went away. Indeed, there exists no evidence that they were directly dealt with by white health care providers.

1950s New Opportunities

An important national event of the 1950s was the beginning of a massive Civil

Rights Movement. Fed up with the segregated rules imposed upon them, and working alongside empathetic whites, the movement's leaders began to challenge the "separate but equal" notion that kept these laws in place. Across the nation these laws were being challenged, groups were organizing and sitting in, marching, and petitioning. Louisville saw its share of Civil Rights fights. One which proved to be most influential to the healthcare system will be discussed in this section. However, nationwide judgments were being made regarding the constitutionality of such segregated systems as the education system and public transportation.

The 1950s brought a great deal of change within the health care system of Louisville. The leaders of Red Cross Hospital were successful in raising the \$450,000 they had campaigned for in 1948 and built and opened the new building, the Alex Heyburn Memorial Building, in October 1951. The new building made it possible for the hospital to offer care to 100 patients. It was resurrected with modern medical and surgical equipment, and even had a new orthodontic clinic for children. This is the first time such service was being offered to young black children in Louisville who needed their teeth straightened (Lux, 2006). Things were really looking up for Red Cross Hospital. However, there was a change in the air that would forever alter the hospital's ability to fully secure its future and within two decades it would be closed.

Although the St. Joseph's Catholic Hospital had apparently admitted a small number of black patients to its hospital in the late 1940s, it was certainly not common practice for any white, private hospital to admit black patients in the entire state of Kentucky by the year 1950. In fact, due to such an uncommon practice, an entire campaign was started to bring about change of such a fact. On August 27, 1950, three

black men were traveling in a car in Breckenridge County Kentucky, when they were involved in an auto accident. Badly injured, the men were taken to Breckenridge County Memorial Hospital in Hardinsburg, Kentucky. The hospital had “no facilities for the treatment of colored patients” (Louisville Defender, September 1, 1950). Since there was no facility for their treatment, the hospital emergency room staff left the three men on the concrete floor to await transportation to Louisville, which required a considerable wait. While the men waited, the staff did not clean their wounds nor assess their medical needs, they only medicated one patient, possibly with pain medication, as the white staff claimed the man was, “so violent he could not be held upon a bed or the emergency table” (Courier-Journal, February 27, 1951; Louisville Defender, September 1, 1950). One of those men died before he was picked up by a Louisville mortician that was sent to fetch them. The other two, badly injured, had to endure the long trip back to Louisville for care. Since segregation was the norm of the day, and the hospital did not have a segregated ward, they did not understand the negative response the incident received once news of it reached Louisville’s black community. In their minds, they had done all that anyone would expect of them (Courier-Journal, February 27, 1951). The incident was written about in the local black newspaper, the Louisville Defender, and caught the attention of several individuals in the community who had been advocating an end to segregation. Most notably, it caught the attention of Anne Braden, who was a budding activist at the time. The Interracial Hospital Movement (IHM) was organized Anne and comrades and they set out to recruit supporters. Creating awareness and soliciting empathy from like-minded individuals in the community, the IHM solicited 10,000 signatures and petitioned then Kentucky Governor Weatherby to act. The group cleverly

used the argument that even though many of the hospitals which would not admit black patients were private, they were tax-exempt and that they, therefore, were indirectly using tax money. The group demanded that the hospitals either open their doors to everybody or stop paying taxes! (Interracial Hospital Movement flyer, 1951).

The organization also pushed to ensure that hospitals which received the Hill-Burton Funds be in compliance with the Hill-Burton regulations which prohibited discrimination. State hospitals opened up, which included the Jefferson County tuberculosis hospital, Hazelwood Sanatorium. Eventually, and with the urging of the Kentucky Medical Association, the state passed a law opening all state licensed hospitals to admit black patients (Fosl, 2002; K'Meyer, 2009). Things did not change overnight, however.

A policy dated 1952, found in Norton Hospital archive, shows that the hospital administrators were aware of the change but had no real intention of changing their habits. It stated that the emergency room would admit black patients for basic emergency room service but under no circumstance would that patient be admitted as an inpatient to the hospital. Furthermore, if the patient needed an X-ray, the patient would need to wait until all white patients could be cleared from the X-ray department before receiving such services (Norton Hospital Policy, 1952, Norton Hospital Library Archives). Former Norton Hospital administrator, Wade Mountz, distinctly remembers that no black patients were admitted to Norton Hospital until after he was appointed as administrator. He had been at Norton Infirmary since July 1950 as assistant to the administrator and states that his former boss would not have allowed the admission of black patients. Mr. Mountz remembers the first black patient admitted to Norton Hospital was admitted sometime

after he was appointed hospital administrator in 1958 (Wade Mountz, 2012).

The *Brown vs. Board of Education* ruling was also instrumental in creating change to the health care system in Louisville during the 1950s. Although the suit was filed on behalf of students in the school system of Topeka, Kansas, it brought to the forefront the injustice of all segregated institutions which assumed the notion of “separate but equal”. Leaders of the city’s medical and nursing programs began to accept black students into their programs. The first white nursing school in Louisville to open its doors to black students was St. Joseph’s Infirmary in late 1952 (same year that the University of Louisville desegregated as recalled by Dr. Milton C. Young, III). Others followed suit and St. Mary and Elizabeth’s Hospital, as well as St. Anthony’s hospital nursing programs opened their doors to black students in the fall of 1953. The Louisville General Hospital (formerly City Hospital) Nursing School opened its program to black students in 1954. Flora Ponder was the first black student to apply to the program when she learned that the school would end its whites-only policy. She recalls a feud between Louisville’s Mayor Broaddus and the schools headmaster, Ms. Ann Taylor.

Ms or Mrs Taylor, I am not sure which, was a director of nurses and she just swore that there would never, as long as she lived, be any black students that would be in her school. (Ponder)

Image 9 shows the integrated nurses dorm. Several students are in what appears to be a normal morning routine (one is in housecoat). Three are white and one is black. This photo is ca. 1960. The names of individuals in photograph are not known.



Image 9: Louisville General Hospital Nursing School Dorm, ca. 1960s. (University of Louisville, UARC with permission)

Ms. Ponder was encouraged to apply to the program by her mother-in-law. Having started a nursing program in Indiana in 1951, before any nursing program in Louisville was open to black students; Ms. Ponder had already established that she was qualified for such a program. Her mother-in-law and family and friends felt as though the nursing program leaders might try to say that no qualifying students had applied, in order not to fulfill the open-door policy. They knew that Ms. Ponder, having been successful in a prior nursing program, would more than qualify. The mother-in-law encouraged her to make application, promising to help with the two children that Ms. Ponder now had to take care of.

They wanted someone to go that they couldn't turn away...and someone that could hang with them too. I laughed because I thought 'I got these two babies to hang with and a husband'

Ms. Taylor, being she, I guess, being faithful to her career plan. She did stay that month I guess, or gave them a months' notice. But she would never, ever, ever, speak to me, she would never. We met in the hall, like a, from where the morgue was in the old General Hospital, there was like, what we call a pedway today, locked in at the hospital and the nursing home, the uh, dormitory, was on Preston Street right there at Chestnut but there was a long walk way and it was just a hall with, uh, two sides. And a couple of times she would, we accidently met in that hallway and she made sure she walked as close to that other wall with her head turned in the direction, which was nothing to see. She never, ever spoke to me, you know, while I was there. And Miss Henninger was the head, uh, instructor and she made notice that she didn't care too much for nigras, nigras as she called it, BUT she was a fair woman and she would always be fair, she let that be known. (Flora Ponder)

Two other nursing programs in the city were conducted through Kentucky Baptist Hospital and Norton Hospital. A 1961 Norton Hospital document, written by Mr. Mountz, states that although the program had opened to black students that year, it had not yet had any "successful" applications. So apparently, the school continued to remain closed to black students until then. Looking through the photographic collection of Norton Hospital Library Archive the first black nursing students appear in a photograph that is undated but looks like it may be from the late 1960s. Image 10 indicates that in a

late 1960s graduation class, there were only two black students in the entire class.



Image 9: Norton Infirmary Nursing School, ca. late 1960's, Norton Hospital Library Archives.

The archives of Kentucky Baptist hospital were not available for analysis but a look at the graduate student composites over the years between 1940-1976 shows that it was not until 1969 that a black student appeared in the graduating class photo.

Interestingly though, a ca. 1950 photograph shows an all-black “maintenance” staff of about 25 men and one white manager (Thomas, 1990).

The University of Louisville Medical School opened its doors to black students in the early 1950's as well. In 1952 it received its first black medical student, Joseph Alexander. Then, in 1953 Dr. Grace James and Dr. Orville Ballard (both black) were appointed as clinical instructors on the staff of the University of Louisville Medical School. In 1953, Dr. Maurice Rabb, Sr. was admitted to the Jefferson County Medical

Association, which had previously omitted black physicians (Morris, 1987). It would be nearly another decade before the first black medical school graduate would attend medical residency at the General Hospital.

Things were changing for black health professionals, but still the majority of the city's hospitals continued to keep segregated wards for black patients or not admit black patients at all.

There were all these wings and there was white male, colored male, white female...there were segregated wards in '56. Um, but the students, regardless of color, were on both wards. If a patient felt bad about having a, uh, black medical student, junior doctor or whatever the hell they called us, come in to take a history and examine them, that was just too bad. That is just the way it was. (Leonard Goddy, MD)

Image 11 shows a white nurse at the Louisville General Hospital caring for a black male patient, ca. 1957. This confirms that by that time, at least, white female nurses were caring for black male patients.



Image 11: Louisville General Hospital Nurse and her patient, ca. late 1950s. (University of Louisville, UARC)

Louisville General Hospital continued to maintain segregated wards until the mid-1950's. Helen Meyers was one of the first black students to graduate from the Louisville General Hospital Nursing Program. She recalls the early days of desegregating the wards:

I think Louisville did very well but I tell you, it's strange, there was this lady named Ms. McGill, who was a black lady, at Louisville General, she was a head nurse there and they had integrated the patients because they used to have the colored wing and it was so funny because she said that when they integrated the patients that every morning she would go, at night somebody would go ahead and put all the black patients back on this end and all the white...and she said that she would spend half of her morning putting the black on here...(laughs). (Meyers, H.

Interview with Arnita Jones March 17, 1988, recording housed at the KLHC)

Dr. Wayne Kottcamp, who was an orthopedic resident at the old General

Hospital has the following recollection:

...I had gone out, out there (California in late 1950's) in the Navy and came back...it used to be male medical white, male medical colored and uh, we never, all the time I was here it didn't make any difference who...when I was a student, I think it was mostly black and white separated then. I think along that time...there were a lot of black patients, you know, too.

“Blacks at General Hospital got really good care. I mean no doubt about that I can tell you that for everybody, nobody really cared, some of the old docs that meet now talk about we, some of the black patients that we treated, they would come to see you later.

Alma Wilson, who started the Louisville General Nursing program in 1956 does not recall the wards being segregated. She states, “it was mostly together...mostly”. Apparently, there remained a tendency to keep black or white patients clustered together. Her sister, Jessie Howard began work at the General Hospital after completing practical nurse training at the Central State Hospital in 1959 and she states, “mostly they put them, the whites, together...mainly where they put the white ones, it was more private, it was about four beds in there and they could close the door, you know”.

In a Jewish Hospital history book it is stated that the hospital began to admit black patients in the late 1950's (Zingman & Amster, 1997). However, a document found in Red Cross Hospital archive collection sheds a little more light on that situation. The document, dated 1957, is a list of the other hospitals in Louisville which treated black

patients and the number of beds they had reserved for those patients. It shows that Jewish Hospital had one semi-private male and one semi-private female hospital bed available. So apparently, although they did not completely exclude black patients, they were not exactly “open” either. The only other hospital listed on the document is St. Joseph which had 8 semi-private beds and 5 ward beds. St. Joseph had no obstetrical ward beds available to black patients, however. All the beds were for medical or surgical patients (Red Cross Board of Directors Minutes, 1957). This shows that well into the late 1950’s, as segregated hospitals were being challenged, segregated wards and a limited number of available beds for black patients within the hospital may have been very common.

St. Joseph Catholic Hospital, mentioned earlier in the newspaper article by Dr. Altman, did continue to admit black patients on a case based scenario. Just as Dr. Altman had predicted, a segregated ward was created. Former Nazareth Nursing School Student (now Spaulding University), Thelma Jackson, did her clinical at St. Joseph’s and recalls a special four bed unit for black patients when she started their in 1954.

There were black patients on the, 3 West, the third floor at the far distant end of the corridor and you went through a dark, you went in a door, and then there was a long vestibule and then to your, to your left there was a real tiny room and then I think to your right was another tiny room. And so it probably housed about four black patients at one time. That was a policy. That was rule; they would not admit black patients anywhere else. If they had a hysterectomy they were back there. If they had a broken leg they were back there.

In regards to the black ward at St. Josephs, there was some change in practice by 1958 when Ms. Jackson was employed there:

They had loosened up. But it was a very, very slight movement. The aids were fussing 'cause I worked on ortho. And um, they did admit a black patient who had been in an automobile accident. We had no intensive care and no recovery room. So anyone who was injured came directly from the emergency room to the unit and I remember going into the kitchen, they had huge kitchens, and there was one open off each wing, so they were, had come in the side door, hidden by the fridge, and I had come in this door where the stove was. And uh, she said, 'I don't mind working with them but I sure don't wanna take care of em'. He was an ortho patient and he didn't stay there long. I am assuming they had no choice, I am assuming they had no choice. And I am assuming that it was an emergency truly an emergency situation and the person didn't stay there longer than one or two days...they kept them in the hospital a long time then. It wasn't unusual to have an ortho patient eight straight weeks. (Thelma Jackson)

Another hospital that opened its services to black patients in 1957 was Kosair Crippled Children's Hospital on Eastern Parkway. During Red Cross Hospital Board meeting minutes for April 18, 1957, board member Charles Tachau reported that the Kosair Crippled Children's Hospital (on Eastern Parkway) had not integrated because "they did not want to create any competition with the Red Cross Hospital". The board members decided to have the hospital administrator pen a letter to Kosair Crippled Children's Hospital officials and inform them that "Red Cross would not consider any

such move as one of competition” (Red Cross Board Meeting Minutes, 1957). The response that they received from Kosair Hospital on June 25, 1957 was:

The Board of Governors and the Staff of Kosair have been very much interested in your hospital, interested in your success in meeting the needs of your people. And certainly, we would not want to do anything that would weaken your program.

You will be interested to know that we have been admitting colored children for the past month. We shall continue to be interested in your hospital and any time we can be of service to you, do not hesitate to call on us. (Kosair Crippled Children’s Letter, 1957, Red Cross Hospital Collection)

Eerily, Kosair leaders had forecasted the very factor, competition by white hospitals, that would be the demise of Red Cross Hospital in the very near future.

1960-1980 Where did the racism go?

The 1960’s brought a significant amount of change for black Americans across the country. Thanks to the activists who sacrificed much to the Civil Rights Movement, Title VI of the Civil Rights Act, passed in 1964, and made it illegal to discriminate against someone, based on race, at any program or activity receiving federal assistance. While this concept had to be enforced, and sometimes required lawsuits to do so, the former practice of separating individuals in public life based on race, appeared to be put away.

This included hospitals and other healthcare organizations. Patients could not be denied treatment and treatment could not be segregated once the patient was admitted. In addition, black nurses and black doctors looking to practice in these facilities could not

be turned away due to race (Reynolds, 1997). There was no evidence in the archival material to suggest that any of the hospitals in Louisville, Kentucky were not in compliance with this law in 1964. However, just because a hospital no longer held its doors closed to black patients does not necessarily mean that it opened the doors widely, either.

Many hospitals across the United States remained non-compliant with the law (Reynolds, 1997) and effort was made to remedy that by passing the Medicare Act in 1966. The act included a stipulation that a medical organization could not receive funding from Medicare until they had been certified to be in compliance with the Civil Rights Act (Reynolds, 1997). Although documentation of any violations in Louisville could not be found in the archive material, a Louisville obstetrician (African American) named Albert Harris claims to have conducted an investigation of the hospital integration process as retold for Jewish Hospital's history: "President Lyndon Johnson appointed me in the early '70's to investigate how well the Hill-Burton hospitals in Louisville were being integrated. We found one noncompliant. Some were integrated, but I didn't see any black physicians" (Aigman & Amster, 1997, p. 90). However, as the Medicare Act was passed in 1966 (becoming the basis for integration of hospitals at that time), and Lyndon B. Johnson left office in 1969, it is likely that Dr. Harris had his dates a little askew and the investigation he mentioned likely took place in the early to mid-1960s. Attempts to locate the aforementioned report, even to the point of contacting the LBJ Presidential Library, were futile.

By the mid-1960s, and due to the integration of white hospitals in Louisville, Red Cross Hospital began to see a rapid decline in its patient census. This fact, largely the

result of black patients making the choice of attending predominately white hospitals which had recently opened their doors to them, would be the beginning of the end for this unique hospital in Louisville. Primary care physicians were beginning to refer their patients to specialists for most of their hospital based needs at this time and specialists were not likely to practice at Red Cross Hospital. Alma Wilson remembers: "And see there was, that, you could see it because a lot of, only thing you got was, if he did surgery at, say at Norton's, and the patient got infected then he would admit them to Red Cross for care." "He could have done that surgery at Red Cross." When asked if he chose not to: "Well I don't know if he or the patient did, I can't say that. I just say, it may not have been Norton, but I am just saying that it was at one of the other hospitals. When asked if this happened frequent her reply was, "uh-huh".

The hospital lost its state funding when the other hospitals began to accept black patients and it was no longer the only private hospital accepting black patients:

You see when all these institutions were segregated; the state felt it was an obligation to help provide for their constituents. See, the black constituents they provided hospital services, the state paid it, the city paid it and at that time you couldn't go down to General Hospital to be a nurse, you couldn't go to General Hospital to be a lab tech, you couldn't go to General Hospital to be an X-ray tech...that was the only place for the blacks to come to because all the other agencies were segregated. But after that stopped, then you'd be saying what is the need for it, unless it can carry on its own self. I mean, why should we support it. So that's when the state, because in other words they began to show had they supported us and not supported another institution, then they would say its

segregation. You see, because they were supporting us and giving us money to help operations, and they wouldn't give it to a white institution to help operations, then of course it would be segregation, so they cut it out. (W. Johnson, 1979)

Once Red Cross lost its financial backing from the state, the already constrained daily operations became crippled beyond repair. Former Red Cross Hospital nurse Alma Wilson left in the mid-1960's when things began to really get bad. She remembers:

Yeah, it started happening then and I got out! Lack of funds, lack of care. I got out because I couldn't handle it. People started going to other places. The patients did. And some of the doctors were nasty too. Some of the white doctors was nasty. I almost cussed one out one time. I went to change a dressing and he just messing up my cart and I let him have it. (Alma Wilson)

It was like a vicious spiral. Low funds led to poor ability to provide adequate care. Less than adequate care led to reluctance by patients to patron the hospital, especially when they had the ability to be admitted to other hospitals. There was also the assumption that the white hospitals were better than Red Cross Hospital simply because they were run by white people. Flora Ponder said it was the idea that "white is right" was ingrained into many black Louisvillians minds at that time. Dr. Jesse Bell was on staff at the Red Cross Hospital when it was forced to close in 1976 and states:

Well, I think maybe, I mean, it would be only a guess—the individual, let us say, who has had only the short end of most things whatever they are—let us call food—and because he has only had food that was limited to ordinary variety, then the next thing that he wants, if opened up and get the opportunity, he wants to

shoot for caviar. Human nature is human nature regardless, I believe, to whatever it is, it's a matter of trying something different, don't you understand. (Bell, 1979)

Similarly, former Red Cross Hospital Administrator, Waverly Johnson, uses the analogy of automobiles:

My feeling was then, and still is, anything that is new people will go to. So when the other hospitals became open for integration, they, or the people who felt that they could get better service there, went. But I think if you would have a survey made and analyzed, that if they would be honestly about it they will tell you the service was no different. But they felt this way, it's the way of feeling, you know. If you're riding in Ford and you've always wanted a Cadillac, you always feel that if I get that Cadillac it'll do things the Ford won't do. But once you get the Cadillac, you'll find that the only thing it will do is to take you where you want to go and it will bring you just like the Ford will. Now you may do it in a little more comfort, but where the hospitals are concerned, I've always felt that as long as we offered quality care, tender loving care, to our patients even though our hospital was not totally air conditioned, you may say, well that's the reason I don't want to go. These are things that I believe that people went to other institutions at the beginning.

Throughout the country, there seemed to have been a movement that anything that was run and operated by blacks was not up to standards. They had to be inferior to some degree...the same fever hit Louisville, that well, why have a Red Cross Hospital that's not up to par? And the thinking of people, what they call up to par. I say we were up to par. Why? Because we were able to pass the joint

commission surveys and all just like everybody else. So we have our certificates and everything, so I say we are up to par. But that doesn't mean anything to the individual out on the street, you understand? (Johnson, 1979)

However, it may not just have been the wish of the patients to seek care at other hospitals. The demise of Red Cross Hospital was highly contingent on the admitting practices of its physicians, some white, but many black. It appears that the younger doctors, especially, could not overlook the fact that there were other hospital doors open to them which afforded them more comfortable and state of the art surroundings with which to practice. Wade Johnson, former administrator, speaks on this:

You know, the older doctor had much more experience in reference to what happened down in this community for blacks in terms of their middle class structure, okay? Now, General Hospital, is always open to the indigent, it was always open to the indigent. The middle class black that had a fairly decent insurance and all could not be taken anywhere; the other hospitals would not be taking them. Our doctors knew this, but when the younger doctors came up, when the younger doctors came in, they could get privileges at these hospitals, you understand? So that when you ask them to come over to here, to this institution, that this other doctor has worked hard and tried to (inaudible) and all that many of the people, I understand the doctors, I'm not going to blame the doctors for it, even though people say the doctors are the cause of it. Many of the people wanted to go to these institutions, too, as well as the doctors enjoy practicing there. (Johnson, 1979)

But there were changes that came about and possibly the early changes in progress and routing to the Red Cross began to drop off some because the other hospitals had opened up, and that within itself made other alternatives available. And that is what I feel may have been the decline in the continuous patronage and you can readily see that many physicians, regardless of how devoted they were, they attempted to keep their patients together...but I would say sometime after '50 that there began to be less visible support for the hospital (Bell, 1979).

...when as I say when other hospitals opened up and certain doctors were given privileges, their reasoning to me was, that their patients requested to go there.

One of the other things that the other hospitals offered that our hospital could not offer, and that was coverage of a physician. We didn't have a house staff, and we were short a house staff, so when other hospitals had house staffs, that if they needed to see a doctor three o'clock in the morning, instead of having to call the doctor, getting him out of his bed to come to the hospital, they had a doctor on site. That was, those were some of the things that I feel that caused our doctors to go to other hospitals....when Red Cross Hospital started, for a number of years, we classified it as a general practice hospital, okay? We had surgeons, and you must remember that prior to 1954, that there were, black doctors could not operate in the other hospitals in the city, and they didn't have, you know, they had the training and all, but they were not part of what we call the total system. Then when the doors opened, and these doctors were given privileges there, that it was very difficult to say that, here you walk into a surgical suite and you have all the

people and all the personnel and everything you need at your fingertips, and then you say bring them to another one where you had the personnel, true enough, but you didn't have as many, and you don't have as much equipment to work with, you know in a hospital equipment means a lot. A lot of times what we call lifesaving equipment is the type of equipment that you may need once this year and that's all. But somebody has to pay for it, you understand, and the hospital didn't have the money to buy this kind of equipment to protect. (Johnson, 1979)

When the movement or the issue of integrating hospitals came about, many of the doctors there (Red Cross) began to practice in other hospitals. Now, they give their reasons, and it's hard to counter medical reasons if you're not a medic, but there became an issue: the question of why, then, so many blacks began to go to other hospitals for the same services they had gotten at Red Cross. The public, certain board members, staff people, contended that the doctor, in order to build his prestige and for ego reasons, began to practice, would take his patients to other hospitals. The doctors when questioned about that issue said that the doctor doesn't take the patient to a hospital; the doctor takes the patient where the patient wants to go. So if they say they want to go to X hospital, that's where we service them. I don't know that that issue was ever settled, but it became one of the sort of termite issues that began to beset Red Cross. And when I say termite issue, I talking about that thing that eats away at a foundation until it collapses on you and you really don't know what's happening. That issue never was settled. The doctors began to move to other hospitals. And that was not, as I see it, based on the economics of the practice and all of it was not based on this ego trip that I

spoke about. Some of it was based on what I define as professional jealousy.
(Beard, 1979)

The Red Cross Hospital board members attempted to identify ways to be competitive with the white hospitals. Unfortunately, with less and less patronage by physicians or patients, it was virtually impossible. As early as 1972 the writing appeared to be on the wall. A *Louisville Cardinal* article announced “Everything but Patients: Red Cross Hospital struggles for survival despite setbacks, bad image”. The article is accompanied by images of empty halls and empty newborn cribs. The article ends with the following statement:

The next several months could be crucial in the hospital’s survival. Employees are dedicated and willing to provide their services; the equipment is top-rate. All the hospital needs now are some patients.”(Red Cross Reference files, UARC, 1972).

Sadly, the patients were not to come. In September 1975, the hospital, by this time renamed “Community Hospital”, closed its doors for good. The city’s only hospital built and run for the purpose of caring for the city’s black residents was now a part of history. Louisville doctor, Milton C. Young, III remarked of the hospital, “this was a place you could go and know you were going to get helped, not hassled.” (Courier-Journal, February 21, 1988)

One other institution, which was started in the late 1960’s, sheds some light on the health care system as it applied to Louisville’s African American community. That institution is the Park DuValle Community Health Center. Opened in February

1968, the center was the result of combined efforts of the American Friends Service Committee, Louisville native Worth Bingham, U.S. Public Health Service officer Dr. Harvey Sloan (later the mayor of Louisville) and the Office of Economic Opportunity. The idea behind the center was to have a health center in Louisville's low income, inner city community of Park DuValle, that was largely staffed by local residents and catered to the health needs of that neighborhood, and to greater West End residents as well. It was especially meant to create a prevention focus for the health needs of what was a predominately black, low income area.

In 1971, the center was transferred from the Office of Economic Opportunity to the U.S. Department of Health, Education and Welfare. Dr. John Howard, originally from Chicago, came to work at the clinic. He recalls: "I moved to Louisville after seeing an advertisement in the New York Times, about a new medical venture, at that time, starting in Louisville". The advertisement, he says, claimed that the new health center would have a different approach to medical care. He found the ad enticing and he and his wife moved down to Louisville. He began working for the clinic the day it opened its doors and remains there to this day. The clinic, which has had some change in funding over the years, remains in place within the Park DuValle community and continues to be a leading source of primary care to West Louisville residents.

During the late 1960's, the Louisville and Jefferson County Health Department had made some changes in the way it delivered services to the community. The reason for these changes is not clear from the data, however, it appears to be due to the change from segregated to desegregated care. Gone were the days when black nurses and physicians were solely assigned to black communities. At this point, the staff and the

staff's assignment were made with no regard to race. No longer did the nurses have assigned territories in which they regularly held clinics and visited families.

There is very little else in the archives after the 1960's that demonstrates the difference in care between white and black Louisville residents. Louisville and Jefferson County Health Department reports began to use the terms "white" and "non-white" to reference race. It is probably safe to assume that most of the "non-white" were African Americans, but it is not clearly defined. The death rate of "non-white" individuals remained considerably higher than "white" individuals from the 1960s-1980 and reflect similar statistics of today. Tuberculosis had ceased to be a deadly issue. The number one killer of black and white Louisville residents was heart disease. Right behind heart disease was cancer. These statistics lead us to our current era, and we continue to see disproportionate numbers of disease burden and quality of care in regards to black patients when compared to white. This will be dealt with more fully in the discussion section.

Part III

White Health Care Provider's Attitudes and Assumptions

This section will reveal the findings in the primary source data and interviews which answer the research question, "what were white providers' attitudes and assumptions about black patients in Louisville?" These assumptions and attitudes were

evident in most of the archive material from the period of 1865 through the late 1940's. Then, they no longer appear in the archive material in object fashion. In general, white health care providers had the attitude that they were not responsible for black Louisvillians' care unless it impacted the white community. In addition, the white health care providers and city officials seemed to consider black residents as "undesirable". These attitudes were made up by the stereotyped assumptions that white health care providers had regarding black residents as 1) lazy and burdensome, 2) immoral and unethical (especially in the area of sexual activity), 3) unclean and 4) unintelligent and childlike.

Undesirable

Some source material demonstrates a general sense that black Americans were "undesirable" to white health care providers. These may not give palpable reasons for the undesirable, but show the attitudes that white health care providers had in dealing with black patients or black health care providers. Such can be seen in the following text excerpts.

The refusal to assist Dr. Fitzbutler while caring for the burned patient: "We won't work with a Negro" (speaking about Dr. Henry Fitzbutler, Cobb, 1952). Or in the embarrassment that the City Hospital physicians worried they would receive if their peers were aware that they were caring for black patients:

Considerable time was given to the wording of the Report in the section on Hospitalization of the Negro and the advisability of omitting the sentence mentioning the City Hospital. Dr. Graves urging the omission of this sentence as its being retained in the report would result in embarrassment to the Hospital and

Medical School and would not assist in the general public program relating to the Negro Health. (Community Chest, ca. 1926)

It is also evident in the thought that the city's black population death rate was due to the black resident's "inherent weakness":

The relatively high death rate among our colored people of course maintains the mortality rate of our city at a much higher figure than it otherwise would be, but the undisputed fact that this high death rate among the colored population is due in large measure to inherent racial weakness does not mean that it is a hopeless task to reduce. (Louisville Health Department Annual Report, 1904, KLHC)

Of course, the mere fact that segregated care existed is evidence of an attitude by white health care providers that black Louisvillians (patients or health care professionals) were undesirable. Segregation was strictly enforced as can be seen in the following excerpts:

At least two free public bath houses should be erected for the sole use of the colored population. Or if this cannot be done, the bath-houses should be arranged in construction as to accommodate the white and colored population separately.

(Louisville Health Department Annual Report, 1903, KLHC)

"The present space and facilities at the City Hospital for psychopathic cases is not only inadequate as to capacity, but because of the limited space it is impossible to segregate the races. This is the only department of the Hospital that is handicapped in this manner." (from A History and Development of the Psychiatric Department at the Louisville General Hospital 1913-1948, ca. 1948,

Louisville General Hospital Collection, KLHC)

Not only were black patients not to be treated alongside white patients, but white nurses were not to care for black men.

Dr. Henry E. Tuley, Superintendent of the City Hospital has made a statement in answer to the criticisms of the institution by the June grand jury in its report Friday.

These criticisms were in substance that white and colored patients were found in the same ward by the grand jury, with white nurses attending both and with both using the same baths...

The use of the pavilion as No. 4 and under criticism by the grand jury for white and colored men, was an emergency measure, and done at the special request of the genitourinary and rectal surgeons so that their special cases could be segregated while the hospital was so full, otherwise a number of patients would have been denied admission for lack of bed...The colored men occupied the rooms opening on the hall, the white men occupied the larger rooms and wards at the south end of the pavilion...the statement that white and colored used the same bath room and toilets is entirely incorrect...they had separate toilets and but one bath tub. The colored patients not confined to bed were given their baths on the male surgical colored ward on the third floor, and never used the white men's bath room.

The statement that white nurses care for the male colored patients is entirely incorrect. There are five colored wards in the hospital, and at present there are 106 colored patients in them. The white nurses on the male colored

wards are there as supervisors only, to see that the staff's orders are carried out, keep the charts written up and give medication. The actual medical care and nursing of the men is performed by male orderlies on each male ward. We would much prefer that there be no female white nurses in any of the colored wards, and plans are being formulated in collaboration with Miss Patty Semple and Mrs. James B. Speed whereby an affiliation may be had between the City Hospital and the Red Cross Colored Hospital Training School for nurses. The colored pupil nurses of this hospital would have one year's training at the City Hospital, thus relieving the colored wards of white nurses. This change involves the working out of many details, which takes time and much careful consideration. In this connection I would state that there has never been a complaint from any nurses in her assignments to the colored wards." (WPA, 10-60, 1916)

We see the lengths that white health care providers and officials went through to protect the custom of segregation. This can be seen in regards to the Jefferson County Poor House, which was under supervision of the county commissioners and offered homes to the indigent elderly : "The colored inmates are cared for on the same property but at a considerable distance from the main building. The buildings occupied by them are very old and are apparently the original farm buildings" (Community Health Chest, 1927).

Apparently, the county commissioners chose to house the black residents in barns rather than place them alongside white residents.

In regards to Waverly Hills Sanatorium:

Immediately following the opening, patients from the wings of the old sanatorium

were moved into the new building. Children were placed on the fifth floor. Their play equipment was set up in the area just outside the wards. All white patients in the building in which advanced cases were treated were moved to the new building. The eleven Negro patients remaining were placed in the west wing. There were six men, four women, and one child...Another problem of even a more serious nature was the shortage of nurses in the colored division of the hospital. Often Mrs. Barrens would be the only nurse on duty. (History of Waverly Hills, undated, Waverly Hills File, University of Louisville, UARC)

Consider the example of a college writing assignment by a University of Louisville student in 1940: “The hospital (Deaconess Hospital) at its present location, which is 529 S. 8th St., is in one respect, unfortunately located, since it is in the heart of the negro settlement”. (Lyon’s Papers, University of Louisville, UARC) Her assumption that the location of Deaconess Hospital within a predominately black area of the city deems it “unfortunate” demonstrates that whites did not desire to be around black residents in such situations.

A similar situation can be seen in the case made by Norton Infirmary board members in a 1962 feasibility study while investigating the potential of opening a second hospital in a suburban area of Louisville:

Hospital requirements are influenced by the size and character of the population served...In the past decade, the city of Louisville, like many large cities, increased its population by only 6 per cent, while the balance of the county increased 91 per cent, most of which was in the suburban cities and villages immediately surrounding Louisville. The population of Jefferson County can be

described as quite evenly distributed between males and females and mostly white, with the colored population (12.9 per cent) concentrated in Louisville... Norton Memorial Infirmary appeals to the upper middle and high income groups...instead of expanding general acute beds on the present site, we suggest that Norton assume responsibility for developing a new hospital in the St. Matthews-Middletown area. We anticipate that this growing suburban area will need a hospital...Norton Suburban would serve the income group to whom the present Norton Infirmary appeals, and would be located conveniently for its medical staff...Finally, a second unit would add flexibility to the decision-making of Norton's management. Thus a problem at one location might be most successfully solved through action at the other, as in gradually transferring beds to Norton Suburban if there were significant changes in the racial character of the Norton Downtown neighborhood. (Norton Memorial Infirmary "Confidential Report", March 1962, Norton Hospital Library Archives)

It appears that the Norton Memorial Infirmary leaders were concerned about the racial make-up of the vicinity of the hospital and perhaps of the patients being admitted. They saw the opportunity to send patients to the suburban hospital, in the event that the downtown location became too concentrated with black individuals, as a motivating factor in opening a second hospital. The suburban hospital plan was scratched, however, and Wade Mountz (former Norton Memorial Infirmary President) recalls that the hospital board decided to invest in a new building (the current location on Chestnut Street) downtown and join several other hospitals in creating the medical center that is now in downtown Louisville.

Lazy and Burdensome

Several examples of white health care providers' assumptions that black individuals were lazy can be extracted from the data. The following are an example these assumptions:

The whites allege that they crowd in the villages and towns to escape work; the negroes claim that they do so to escape persecution. There is truth on both sides of the story, but 75 per cent of it is on the negroes side. It is not found that the negro refuses to work when he is fairly dealt with, honestly paid, and well treated." (Letter from Assistant Commissioner Office, State of Kentucky, Bureau of Refugees, Freedmen and Abandoned Lands, Louisville, KY, January 10, 1868, National Archives and Records)

I have accounted for the high death rate as occurring in our colored population by reason of the fact that many of this class of people are improvident, ignorant, uncleanly in person, and indifferent to hygienic precautions, and besides they indulge in excessive venery and other hurtful practices. Many of them have inherited tendencies to scrofulous and tubercular diseases. It is not surprising, then, that the death rate is much greater in the colored population than in the white." (Louisville Department of Health Annual Report, 1903)

It cannot be estimated as to how much of this would contribute to the healthfulness and activity of this class of people and to what extent it would cause them to be more self-sustaining, thus lessening the expense of their maintenance

in our eleemosynary (charity) institutions.” (Louisville Health Department Annual Report, 1903)

Regarding black mothers and the care of their children:

Statistics show that the Negro in Kentucky stands at the top of the death rate. The excessive number of deaths among the Negro population is due mainly to the great preponderance of infant mortality. In part, this state of affairs is the outcome of carelessness, ignorance and neglect of the Negro mother. (The Pre-School Child, 1928, Community Chest, KLHC)

Unintelligent and Childlike

“Under our present authority it is almost impossible to secure complete protection of the community by vaccination, owing to the ignorance, prejudice, superstition and carelessness of a certain portion of people” (WPA-11-99, 1877).

“This is particularly true of the colored tenements....(the housing inspector) orders them to clean up...within a few weeks another inspections reveals conditions almost as bad...hoping that, by constant supervision, it will be finally borne in on them that they must keep their rooms clean.” (Louisville Health Department Annual Report, 1913).

Regarding the black mother and her child:

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Negroes employed at the garage absolutely refuse to enter the ambulance and one asked for his pay when it was insisted that he go inside and clean the interior.

They will clean the outside, polish the brass and do any work that is needed on the exterior, but the line is drawn at passing through the door. The cleaning can be done only during the day time also, as when night falls the negroes fight shy of the ambulance as they would of a haunted house. (WPA, 10-58, Louisville City Hospital, 1914, KLHC)

Negroes are prone to think that others of their race are trying to poison them and frequently bring food for analysis. In most instances they have simply let their imagination run riot, but occasionally some poison is found, and then it is still hard for the technicians to decide whether or not the 'victim' himself placed the deadly stuff in his food. (WPA 12-7, Press Coverage, 1929, LKHC)

Unclean

“This is the very class of people who should be taught the habits of cleanliness.”
(Louisville Health Department Annual Report, 1903, KLHC)

“It will be observed that the death rate as occurring in the colored population was very much greater than that in the white, and this has been explained and accounted for in former health reports and is thought to be the result of habit, environment and a general want of knowledge in respect to proper sanitary and hygienic precautions.” (Louisville Health Department Annual Report, 1904, KLHC)

“The unhygienic conditions under which many of the negroes live, and their very marked susceptibility to the disease (tuberculosis) render the work (of the health department) very difficult, but from the point of view of self-interest, as well as

humanity, it is essential.” (Louisville Health Department Annual Report, 1910, KLHC)

“They live in unbelievable filth.” (Louisville Health Department Annual Report 1913).

In regards to Negro Health Week:

“The health week program throughout the country is both educational and active. Cleanliness and practical principles of right living from the viewpoint of both moral and physical, are preached in the churches and schools, and actual ‘cleaning-up’ of premises and vacant lots is accomplished.” (WPA 14-24, 1923).

Unethical/Sexual Immorality

The following is an excerpt from a letter written by an officer assigned to the Freedmen’s Bureau:

There is another terrible evil, that of “taking up”, or indiscriminate intercourse. It is reported that in various districts there is a general state of polygamy existing. This is the result of slavery and lax administration of the law.

There are laws for the crime of adultery; but they are not enforced by the civil authorities against the blacks. The rebel element are aware that this is the bane of the black people, in fact, a curse upon them, and they prefer should suffer from it rather than correct the evil.

The vagrant laws of the State are so harsh that I should hesitate to advocate the enforcement of them against the colored people. Under the provisions of these laws men and women are virtually sold into slavery. Time and education will remedy this evil. In the meanwhile I scarcely know what can be done. I propose, with your approval, to visit the places spoken of, consult with

the civil authorities, and talk with the freed people, and see if some remedy cannot be devised. Vagrancy and 'taking up' has never been so great as at present or it has never been brought so plainly to view. (February, 1868. Freedmen's Bureau Records, National Archives Records)

Similar thoughts followed throughout the next century. Take, for example, the goals of Negro Health Week: "The health week program throughout the country is both educational and active. Cleanliness and practical principles of right living from the viewpoint of both moral and physical, are preached in the churches and schools, and actual 'cleaning-up' of premises and vacant lots is accomplished." (WPA 14-24, 1923).

Also demonstrating the assumptions of immoral behavior by black residents is this passage regarding tenements: "During the month the Tenement House Inspector arrested a colored man in one of the bad tenements for selling cocaine... They are a rather vicious type of people, who recognize neither moral nor civil law, and keep their rooms indescribably filthy." (Health and Hygiene, Bulletin of the Louisville Health Department, 1914, KLHC)

"The Negro soldier has no difficulty in contacting either a prostitute or 'chippie'.

(Venereal Disease Report, 1945, Jefferson County and Louisville Health Department, KLHC)

Although there was a not an overwhelming abundance of such derogatory language in the archive material assessed, that these exist demonstrate their presence among the white health care providers. There was no data speaking to positive attributes of black Louisville residents by these health care providers. In fact, black residents were infrequently mentioned in much of the health care related archive material which leads to

the assumption that they were not given a considerable amount of attention by the white health care system. And when they were, these derogatory assumptions prevailed.

Part IV

Motivation to Change

What motivated white healthcare providers to change to an integrated healthcare system?

The 1950's brought the beginning of the integration process of the health care system in Louisville. Certainly black Louisvillians and empathetic whites were calling for change. But what actually motivated the predominately white health care professionals and leaders to adopt the change?

Two factors stand out in both the archive material and the oral history interviews. The first is the change within health care whereby specialties and board certification became the norm. Prior to this period, a licensed physician had many roles and could perform a variety of procedures and surgeries. Over time, however, this fell to the wayside as physicians in residency programs began to train for special services such as obstetrics, general surgery, pediatric surgery, urology, cardiology, etc. Hospital boards chose which physicians received privileges in their hospitals and each physician had his or her patient case load which would utilize that hospital service. Hospital clientele, then, was dictated by the doctors on staff (Stevens, 1989). Most of the general practitioners had clinics in specific neighborhoods (and Louisville's neighborhoods were usually black

or white, not mixed) so that their clientele reflected that neighborhood. Typically, white general practitioners served white clients and black practitioners served black clients. However, the specialist, whether it is a cardiologist, urologist or orthopedic surgeon, pulled their clientele from the population that needed that service. If a specialist further limited his or her pool to a specific race of clients, it might have an impact on his or her income. A specialist, therefore, was more likely to see a patient of any race if that patient was in need of the services that he or she offered. The result would be that the specialist would expect to admit his or her patient to the hospital in which he or she had privileges. This was the case with the first black patient admitted to Norton Hospital retold by Wade Mountz:

It was after 1958, because that's when I became administrator. And um, we had a very, um, good urologist in this town called Dr. Robert Lich. And Dr. Lich called me one night, uh and said, very, uh very late in the afternoon he called me and said 'Wade I have a patient that needs to be admitted' and, uh, I said well fine (chuckles) he said 'well', he said, 'it might be a problem, um, she's black'. And um, I said, 'uh, you want her here?' he said, 'yes'. He was a big producer, I mean he had the urology practice in, still in here, and uh, and uh, so I called the board chairman and I said "got a possibility here were going to admit a black person. We've never done that we have no rules against it and so forth, and uh, he said to me, uh, things that he said to me many times during his terms as chairman 'We ought to do it, I don't wanna read it on the front page of the Courier-Journal', (chuckles) He said that to me on several occasions. About other things and uh, so uh, we uh, he came in when she did and uh, Dr Lich, and uh, she was a practical

nurse, and uh, they went up to 4 south which was our urology level and uh, um, she walked in and the nurse that was in the station was a practical nurse and they had been in school together and they grabbed each other and gave a big hug and so forth and so on and, it was, I am sure that was some chit-chat about it but nobody ever came to me and said “what are you doing?” “so forth and so on, and so it was as painless a situation as I could ever imagine. And I think that the fact that that girl, on the floor, had been a classmate of hers, you know there’s an instant bonding there and, uh, I am sure that she probably was helpful to the patient because she, I am sure she told people “she’s a great person” and da da da, and so forth...it was almost a non-event really and we made no, we made no announcement of it, we made no great public, you know, da da da da, and so forth and uh, I just have always kind of considered it a non-event. But I know it was a big event (chuckles). (Wade Mountz)

When asked if this event opened the doors to more black patient admissions Mr. Mountz said:

It was just a gradual situation, I mean, uh, the word was out that it was OK...I know that I was the administrator, I’m, I’m reasonably sure. I was, I don’t think I would have ever done that individually had I not been the administrator, I mean, because that, my preceptor would not have appreciated that (chuckles) and so forth really. Well, I, he, he was the old school. He ran it close to the chest all the time.” “It’s been my memory that was after I became administrator in 1958. That we had that incident and that was what started it. As I say, it was, I have always considered it kind of a non-event.

That, of course, is because we were essentially a specialty hospital. We had very few general practitioners on our, um, our board, in 1954 passed a regulation at the recommendation of the medical staff executive committee that no one was, uh, should be permitted to do surgery if they were not either board certified or had board training and were in that period in where, after they finished their residency where they've got about three years to pass the boards, and , so forth, but...and we had to remove a person or two that had done that and had never taken their boards and so forth...and of course we had all of our obstetricians were board certified except one. We had one general practitioner who had done deliveries there, now this is white now I am talking about, wouldn't have made any difference I mean, uh, in 1954 because it was, uh a tremendous, it caused a rift between the general practice community and Norton that last til this day. There is still people who resent that...I referred to you earlier about the rift that the surgical, situation, you know in the early days most doctors did a little surgery, they did appendectomies they did breast biopsies, they did tonsils and so forth and so on, and uh, our argument on that was that most doctors could do that because they're simple situations but when they get in trouble, they're not qualified to solve that problem of trouble. And that's kind of the way the super specialists looked at it, in a situation and, oh it was an earthshaking battle in 1954 and uh, we had several people that were general practitioners that left the staff and just wouldn't, wouldn't work there and um, I uh, it was a parlous time but our, we had such a strong medical section that they were able to bring patients in for those sub-specialists. Now days we've got lots of general practitioners and of course,

everybody now is looking for family practitioners to bring in patients. That's one of the reasons, you know, Norton owns 400 practices no, and uh, and uh, part of it is that reason. (Mountz)

A similar testament was stated by Thelma Jackson, a black nurse who worked at several locations in Louisville through the years, but was also a health care consumer.

Many white doctors did not take black patients. Cause when I went to this white doctor to get my ear surgery, uh, he was rather cold. And I had seen his work, uh, at the, at the hospital. I am trying to remember. My mother's best friend went out there for surgery. Many of the white doctors would not accept black patients. Many doctors were downtown on fourth street in an office building, and there on third street, third and uh, Broadway. The Heyburn building, that's where a lot of the doctors were, white doctors, and so we tended to go to black doctors unless they said 'I would rather not do this because it's not my specialty' they were all GPs so they would send us to a specialty doctor downtown. So when I went to get my ear surgery, I went to this doctor because I thought that he did good work, you know, I, and when I went to him he wanted to know, 'Who referred you to me?' And I thought, oh gosh, he doesn't want black patients. And I said, well, I had seen you at St. Joe and I said I worked there as a nurse and he was decent but he really was not interested in caring for me. So when I came for follow-up care, the waiting room was standing room, uh, there were no chairs, I had a chair but I had to wait until every patient in that waiting room was waited on before, I was taken. They were all white. (Thelma Jackson)

Interestingly, although Mr. Mountz remembers the first black patient being admitted to Norton Hospital as being a woman in the late 1950's, Shirley Powers has a different recollection. Ms. Powers had started at Norton Hospital as a "candy striper" in 1955 and continued to work at Norton Hospital through the Norton Hospital Nursing program, graduating in 1962. She distinctly recalls the first black patient admitted to Norton Hospital as being a man:

In '59 we had no black patients but in 19—60—1, I can remember when it happened, it was 1961, to my knowledge, was when we got the first black patient and he was a gentleman that came to our emergency room with an incarcerated hernia. And he worked somewhere close to 2nd and Oak and I don't know where he worked. And he was in the emergency room, and I believe Dr. David Kennard is no longer alive, was a general surgeon and operated on his hernia. And it was almost interesting because the word went through the hospital that we had our first black patient...I was a student nurse and my, uh, she later worked for me and her name was Dottie Whitehouse was, her name was Kitchen then, she was assigned to, I cant remember what floor he went to but she took care of him. And she was talking about how neat it was, how nice he was. This is a true story, and uh, I don't remember that I even saw him, but I can remember Dottie talking about him over in the dorm. Cause we lived there at the dorm. (Shirley Powers)

Mr. Mountz's sentiment that admitting a black patient to Norton Hospital for the first time was "kind of a non-event" reflects a perception that there transpired, in the

1950's, a change in attitude among whites in Louisville. This sentiment was reiterated by several of the white health care providers interviewed and is the second factor that appears to have motivated white health care providers to integrate.

I don't think it was any earthshaking news. It was just like, things were changing. And you know, it might have been, now that I am thinking about this and you tell me about the fact that the black people were in the basement eating, and now they were upstairs on the second floor that things were changing. But we were young enough that we didn't think anything of it. (Shirley Powers)

I am fascinated as I am looking at it (the confidential report), because, uh, I know it was bigger than I am making it. My mother used to say that there are no coincidences in the world and the good lord just arranges it that way. I think that the fact that those two girls, that first patient, those two girls were in the same nursing class in practical school and they bonded immediately. I am sure that had a lot of effect on other people, and uh, because it made a big impression on me because I have never forgotten it. (Wade Mountz)

When asked if the admission of the black male with the incarcerated hernia opened the door for more black patients, Ms. Powers states that more came but it was certainly not a large amount.

Um, it wasn't common but after that we did see some black people and I am trying to think, wonder how they got there? I mean, I wonder if the word just spread, I don't know...I graduated in '62 and we left in '73 and it just seems like it just picked up. Now when we came downtown here, um, by that time we were

seeing a lot of black people. Now I don't know what year the Red Cross Hospital closed...it closed about the time we came down here. And we hired some of their nurses which was interesting. The first black nurse that I can remember was "Lucille Butler". And Lucille was a director of nursing at the Red Cross Hospital and Lucille was wonderful... There were very few. We had em, but there were very few. (Shirley Powers)

In the late 1940's, a Louisville physician had been quoted as saying that the likelihood of white hospitals admitting black patients was strictly based on "orders" (or the demand of specific physicians) and that the black community should not expect to see true integration within the white hospitals (Red Cross Hospital Scrapbook, ca. 1948, University of Louisville UARC). The testimonies of Wade Mountz, Shirley Powers and Thelma Jackson corroborate the finding that the initial motivation to integrate the health care system, albeit a slow and limited integration, was the interest of certain white health care providers within the city. It was not an altruistic realization by white health care leaders that segregation was an unethical practice that negatively impacted the city's black residents. Dr. Maurice Weiss recalls that even in the early 1960s there were white physicians who demanded that their black patients come in from a back door (personal conversation with Dr. Weiss on approximately April 13, 2013).

We know that historically, the passage of the Civil Rights and then the Medicare Act of 1966 were intended to promote an integrated system of health care across the United States. There is no evidence that the white health care system in Louisville, Kentucky attempted in an organized way to avoid this integration. In fact, it appears that the health care system of Louisville likely considered itself already integrated. It is not

clear when the hospitals abandoned their segregated ward practice (which would have violated the Medicare Act certification). It is reasonable to conclude, then, that the initial integration of Louisville's white health care system was a direct result of the self-interest of white health care physicians (specialists) and that the continued evolution of that integrated state, however it proceeded, was likely out of continued self-interest of the white health care providers. While there was likely some influence from the changing tide brought about by the gains made through Civil Rights activism, it is not clearly defined in the data. It is very possible that the Civil Rights Movement was instrumental in changing the mindset of these healthcare providers, but the fact that self-interest played a big role is very clear.

The well-known black scholar, and co-author of the Critical Race Theory, Derrick Bell (1980) discovered something similar while analyzing the passage of *Brown vs. Board of Education*, the ruling that led to full integration of public schools. Bell contended that decisions made by white leaders in regards to black Americans were subject to an "interest-convergence dilemma" which held that "the interest of blacks in achieving racial equality will be accommodated only when it converges with the interests of whites" (Bell, 1980, p. 523). What Bell suggested was that whites accommodated blacks, not out of altruism or guilt at harming black Americans, but because of an "unspoken and perhaps subconscious judicial conclusion that the remedies, if granted, will secure, advance, or at least not harm societal interests deemed important by middle and upper class whites" (Bell, 1980, p. 523). This same "interest-convergence dilemma" can be seen at play with the integration of Louisville's health care system. It appears that the health care leaders (in this case physicians and administrators who had the power to

make change) were motivated by the notion that their interests would be advanced.

Part 5

Quality of Care

What was the quality of care delivered to Louisville's black community before and after integration of the healthcare system?

Assessing the quality of care that was available to black patients before and after integration was somewhat elusive. There exists some archive material that speaks to the quality of the care that was available to the black community and those will be presented here in two sections. The first section will reveal those which pertain to the era prior to health care integration and the second section will reveal those pertaining to the era after integration.

Prior to Integration

Prior to the integration of health care in Louisville, the quality of care available to Louisville's black community could be described as rich but inadequate. It was rich, because the care was mostly coming from individuals of their own community or of the same U.S. heritage. This created a personal element that seemed to have some impact on the state of well-being in the black community. This element was likely the phenomenon of what social psychologists label "Altruism Born of Suffering" or ABS (Staub & Vollhardt, 2008). ABS is the outcome of the effects of ostracism, oppression or victimization. Individuals within a group that is being victimized in some way, have a

higher level of empathy and sympathy for other victims, perceive that the victims plight is similar to their own and can identify with the victim, and develop a sense of responsibility for the victims' suffering (Staub & Vollhardt, 2008; Vollhardt, 2009; Vollhardt & Staub, 2011; Westmaas & Silver, 2006). Recently, Hernandez-Wolfe applied the concept to human rights activists in Colombia. She found that the ABS framework guided the understanding of the social behaviors of Colombians who had endured political violence and came through that adversity to be active human rights advocates. The very oppression that they had experienced, guided them to their humanitarian philosophy (Hernandez-Wolfe, 2010). A similar phenomenon occurred amongst black health care providers within the segregated system. For example, the first black physician to call Louisville his home did so because of the need among other black Americans. He was urged to come and "help his people in the south, where there was heavy suffering in an epidemic of yellow fever that struck in 1871 (Hanawalt, 1973 p. 139). This same physician, along with partners Drs. Conrad and Burney, then opened a medical school to ensure that black men (and women) could train to be physicians and further impact the needs of Louisville's black community as well as black Americans in general (Meyer, 2006). The social fabric of segregation left these early pioneers no choice. Surely there were some personal motivators to the career paths they chose, but the greater good seemed to be of primary importance.

Another example of this can be seen in the establishment of the Red Cross Hospital. Although no reason is known as to why Dr. Whedbee and Dr. Merchant chose to open a second black hospital as opposed to working with Dr. Fitzbutler to improve and expand the already existing Louisville National Medical College's hospital, the

motivating factor in doing so was that the doctors recognized that their patients were in need of hospital services. Since funding was always an issue for this facility, it is not likely that the physicians saw financial gain as a motivator in this endeavor. In fact, the Red Cross Hospital consistently charged approximately 1/3rd of the average costs that the white hospitals in Louisville charged (Red Cross Hospital, Board Meeting Minutes, University of Louisville, UARC).

Perhaps nowhere in the archive material is it more convincing that the black health care providers held a personal element of care during the segregated period than in the material that disclosed the role of the black nurse in the black community, and most particularly in her reception by the black community. Flora Ponder's recollection of working with one of Louisville's public health nurses during her nurses training in the early 1950's exposes this. She recalls the people of the community in which the public health nurse was assigned coming out to meet her on the expected date and time dressed in their finest clothes. This testimony speaks volumes regarding the level of respect the black community had for the public health nurse, so much so that they saw it fit to dress in their finest when she came for her weekly visits. Ms. Ponder remembers that the people in the community seemed to look forward to the nurse coming. There was surely some personal element there that would make an entire community dress up in anticipation of the arrival of the public health nurse.

When city officials conducted a feasibility study regarding the purchase of Deaconess Hospital facilities to be used as a black hospital in 1926, they solicited the assistance of authorities in Kansas City to learn what the officials of that city observed in establishing a city hospital for indigent black patients. One of the things the Kansas City

officials shared with them was that having black nurses care for black patients was imperative in delivering quality care.

Twelve years' experience in this work serves to emphasize the following facts:

The use of Negro nurses has made it possible to reach these people...white nurses had little influence over them, and the usual propaganda methods employed effectively for the white population brought about but indifferent results.

(Community Chest, 1926, KLHC)

This passage demonstrates that the black nurse was able to interact with the black patients in a way that made them far more receptive than the white nurse could. It is very likely that this occurrence was the result of a shared bond between the black nurse and black patient. The nurse had a particular sense of compassion toward the patient who was suffering the same racial oppression as she and the patient could sense that genuine compassion.

Later, when the city health department employed black nurses to manage the care of Louisville's black community a similar quality could be seen. These community health nurses made visits to schools, ensured that children were vaccinated, held classes regarding infant and child care, conducted both prenatal and postnatal visits with mothers in their homes, and managed the treatment of communicable diseases within the community. Their personal relationship with individuals in the community was extremely important in the patients' participation. Louisville Health Department leaders wrote this in their 1940 Annual Report:

...additional structuring may be necessary due to the completion of Beecher Terrace. It was recently decided that all clinical work should be done by the

nurses whose districts are in the immediate area served by the Center in clinical work. In doing this, the patients know the nurse before they come to clinic, as they have already been visiting in the home. There is a better feeling of understanding built up this way. (Louisville Health Department Annual Report, KLHC)

Another way that this phenomenon could be seen was in the testimony of Dr. Milton C. Young, III. Young was the first black medical resident to be accepted to the University of Louisville residency program. He, a graduate of the historically black medical college Meharry Medical College in Nashville, Tennessee, recalls how his colleagues quickly identified him as highly efficient at difficult deliveries of obstetric patients. He contributes this to the training he received at Meharry:

They knew that a lot of these doctors (who graduated from Meharry) would go into communities that did not have hospitals for black patients. So they would teach us to deliver the baby in the bed. They would show us all the possible complications that could occur and teach us how to work through it. So when I went to Louisville General, it didn't take long before the word got out that I was particularly good at complicated deliveries. They (fellow interns) would call me down, 'Hey, come and see if you can do anything with this patient. (Dr. Milton C. Young, III)

Dr. James F. Densler, a pediatric surgeon residing in Atlanta, Georgia and classmate of Young's remembers it similarly.

When I got to New York (Staten Island) I already knew how to do a lot of the

things that the second year residents were doing. I was in my first year and I already knew how to put in IV's and perform cut-downs...they already taught us all that at Meharry before we graduated. They put us to work! They needed us to work (at the hospital) because somebody had to take care of those folks. (Dr. James F. Densler)

Here we see an incidence of the black health care provider's sense of obligation to care for the black community and to teach black doctors how to practice to most benefit their patients who were subjected to the same laws of segregation.

Unfortunately, despite the rich quality of care being delivered by black health professionals to the black community, the availability of that care was severely limited in all the years prior to integration of the health care system. At no time during this period did black Louisvillians have adequate health care resources in Louisville, Kentucky.

When the War Between the States ended in 1865, freed men and women flocked to the city of Louisville. Initially, these individuals had no place to seek health care. Within a short amount of time, the federal government stepped and set up a hospital and dispensaries to assist this group with health needs. That was short-lived (three years) and when they pulled out, the city government was given the task of administering care to the black community. While it appears that the city took that task to heart and indeed did provide care to the black community it was limited in scope. The city indigent hospital began to seek indigent black patients into its wards and clinics, but there remained no place for non-indigent black residents to seek care. Slowly, a handful of black physicians trickled in. As could be seen in the chronicle of events, the struggle to deliver care to the non-indigent, black community of Louisville remained an issue throughout the entire

period up to the integration of health care. The health care leaders of the city throughout all the decades chronicled appeared to be fully aware of that situation. However, it appears, that not one individual suggested the integration of health care to remedy it. In fact, segregation was such an integral part of Louisville's society that it appears not to have even been a consideration.

In 1926, the Health Council of the Community Chest and leaders from the Urban League in Louisville conducted a feasibility study of the prudence of purchasing the Deaconess Hospital facility for use as a black general hospital. It was found that Louisville's black community was limited to only two hospitals: Louisville City Hospital and Red Cross Sanitarium. Furthermore, the training opportunities for physicians and nurses were extremely poor. That meant that the health care choices for Louisville's non-indigent black community were few. The following report demonstrates the state of health care for this population:

The hospital provisions for Negroes consist of 206 beds at the City Hospital and 38 beds at the Red Cross Sanitarium, a total of 244 beds. For the Negro population of 46,800 this affords a ratio of 5 plus beds per thousand... The Red Cross Sanitarium is a fairly modern brick building conducted for hospital purposes. It has 38 beds—10 of these are in the children's ward. The patients are mainly surgical cases. The hospital has no staff, both white and colored physicians attend the patients. The hospital receives a State appropriation of five thousand (\$5,000.00) dollars annually for the care of sick colored children from the state at large. Colored crippled children are referred to it by the State Crippled Children's Commission. It lacks any facilities for the care of obstetrical cases,

having no delivery room. Patients are delivered in their bed rooms. The hospital serves but two meals a day—breakfast between 8:30 and 9:00 A.M. and dinner at 3:00 P.M...

City Hospital- The accommodations provided at the City Hospital for colored patients do not differ from those provided for white patients. While the Negroes comprise but 15% of the population (46,800 Negroes in 1925) the City Hospital reserves 50% of its beds for the sick people of this race.

The admissions to the hospital for the last four years show a fairly large percentage of Negroes: 37% from September, 1922 to September 1923; 39.5% from September 1923 to September 1924; 41.5% from September 1924 to September 1925; 39.7% from September 1925 to September 1926.

According to Mr. Ragland of the Local Urban League there are 44 Negro physicians in the city, 40 of whom are in active practice...The ratio of Negro physicians is one to each 1,170-1,300 of the Negro population. There are 553 white physicians listed, or one to each 468 of the white population.

It is impossible to obtain even a fairly accurate estimate of the number of Negroes employing physicians of their own race...The medical profession is a comparatively new profession to Negroes and there is little doubt but that as the years go on the Negro physicians will be an increasing factor in the care of the Negro sick.

Colored physicians have wholly inadequate clinical opportunities to permit them to keep abreast of medical progress. The two hospitals for colored patients, while showing commendable initiative and a very considerable effort

supported by both the colored and white populations, are not likely to provide all the facilities necessary for a continuing current education of colored medical practitioners of Louisville.

It is recommended that steps be taken to provide a broader nursing experience for colored nurses and for the post graduate training of colored physicians in hospital work. In doing this it should prove entirely practicable to arrange for such training for both nurses and physicians in hospitals which receive colored patients. ("Report on the Proposed Negro Hospital," 1926, Community Chest, KLHC)

In regards to Waverly Hills Sanatorium:

Immediately following the opening, patients from the wings of the old sanatorium were moved into the new building. Children were placed on the fifth floor. Their play equipment was set up in the area just outside the wards. All white patients in the building in which advanced cases were treated were moved to the new building. The eleven Negro patients remaining were placed in the west wing. There were six men, four women, and one child...Another problem of even a more serious nature was the shortage of nurses in the colored division of the hospital. Often Mrs. Barrens would be the only nurse on duty. (History of Waverly Hills, undated, Waverly Hills File, University of Louisville, UARC)

This is a small representative of the deficit of care availability that existed for Louisville's black community. Since black residents were excluded from all of the white health care facilities aside from the city's indigent facilities, choices were limited and it is

likely that black residents often did without meeting their health care needs as a result.

Post Segregation

While it is apparent that the true desegregation of Louisville's health care system was not an overnight phenomenon, it is true that eventually the choices available to black patients became the same as those available to white patients, on the surface. There is no evidence to suggest that any healthcare facility refused to admit black patients after this point. However, the extent to which black patients were admitted is not known. Furthermore, the very presence of disparities in the quality of care delivered indicates that the quality has yet to be the same as that of whites.

One incident that stands out in the archive material and speaks to this quality is in the changes that occurred after the Louisville Health Department integrated its services. Gone were the days of the black nurses being solely responsible for Louisville's black community. Assignments were made regardless of race. Furthermore, gone were the days of the nurse going out into a community of individuals that she had come to know and care for. By the late 1960's services were being offered from the health department clinic and patients were required to come to the facility to receive them. This may have been to the detriment of the community. One event seems to speak hauntingly of this: the death of a nine year old, black boy named Bobby Ellis in Louisville's predominately poor, black West End "Russell" neighborhood. On Thanksgiving Day, Thursday November 27, 1969, the Courier-Journal reports that 9 year old Robert Ellis was carried to the morgue of General Hospital, dead from malnutrition. The child weighed 30 pounds. His five siblings, ages 1-11 years old, were hospitalized for treatment of the same condition (Courier-Journal, November 27, 2013). Their parents were arrested on

charges of neglect. They claimed that they did not have enough money to properly feed their six children. The mother was pregnant with her seventh child. There was no health department nurse making regular visits in the Russell community and being greeted by residents glad to see her in 1969. What did happen was a series of failed attempts, by non-medical personnel, to address the situation. A year and a half before the boy died, his school principal and the school's "Learning Facilitator Committee" had seen the boy's obvious inadequate health and claimed that "it had been discussed at every committee meeting...it has been worried about and fretted about." The children had not attended the school for most of that school year and a recommendation that something be done was sent by the school committee to the city's school board the week before the death. The school officials felt as though they did not have sufficient information to act.

Meanwhile, two of the children had been admitted the year before for treatment of undernourishment. Upon his discharge from the hospital the mother was instructed to bring all of the children back for assessment. She did not. A neighborhood social worker (it is not clear for what department she worked) attempted to contact the mother about the children "about 25 times" (Courier-Journal, November 28, 1969, p.1) from February 1969 until the week of the child's death. The social worker said that no one had been able to get inside of the home and that occasionally, a man, the boyfriend of the mother, would answer and say that the mother and children were not home. She claims, "I had been doing some homework on some of my cases just this morning and I read through my file on this case. Then I picked up the paper and read about that child starving to death. You have no idea how that made me feel. 'Oh, my Lord!' I said to myself. 'What in the world are we going to do?' (Courier-Journal, November 28, 1969, p. 1).

The story becomes more convoluted. Apparently, in May and June of 1966, the Louisville branch of the Metropolitan Social Service Department (MSSD) had contact with the Ellis family. This organization had been contacted by the child's school because they felt the children in the home were not adequately nourished. The school official stated that they feared the lunch that the children ate at school was the only meal they were receiving each day. While investigating the case the MSSD worker learned that a special service worker from the state Department of Economic Security had already been assigned to the Ellis family. The worker from the local MSSD resigned and left the work to the state agency. An official from the state agency would not give out details due to privacy but disclosed that the family was receiving assistance from that organization. He stated, "If you have a question about why that child starved to death, ask that child's mother" (Courier-Journal, November 28, 1969).

This scenario was symbolic of the quality of care and concern that Louisville's black community lost after the health care system integrated. It is multi-factorial, as no single organization or health care institution could be solely blamed, but it stemmed from a multitude of changes in the way health, health care, and preventive services began to be delivered throughout the city. Before integration, the predominately white health care system in Louisville insisted on segregated delivery. Because of this, the deceased boy's family would very likely have been the recipient of teaching, assistance and follow-up by a nurse who was invested in the community and had a personal concern for its residents. Once integration changed the face of health care delivery, this family was no longer visited by a concerned public health nurse. Instead, the child's school took some action, but stalled on follow-up. Two different social service agencies appeared to take a less

than thorough look at the family's situation. In fact, the state agency says that "we did our part, ask the mother what she did wrong". Furthermore, when social service workers came knocking at the door, they could not get a response from the family. This indicated that a level of mistrust between the social workers and the Ellis family may have acted as a significant barrier during this time. This would not have been likely when the public health nurse was making routine visits to the community and following up within individual's homes. These nurses were reported to have been well-received, respected and trusted by members of the community in which they served.

Summary

The purpose of this study was to chronicle the evolution of health care provided to the black community in the city of Louisville, Kentucky from 1865, just after the Civil War, through 1980 well past the conclusion of the Civil Rights Movement. In doing so, and in identifying the biases that white health care providers held, and which promulgated the segregated system, as well as the changes made when the health care system was integrated, helps us to better understand the current health disparity that exists for black Americans. In essence, to understand where we are today, we need to understand how we got there in the first place.

Just after the Civil War, Louisville's African American community saw rapid growth. Health care concerns were largely similar to the white community but were plagued by the issues of inadequate housing and sanitation, predominate low economic status and social out-casting. Although the city's health authorities did not ignore the black residents, their involvement with the black residents was largely one of obligation, especially as it impacted the health of the overall white community. A paternalistic

attitude was clearly discernible by the way in which the white health care leaders wrote about black residents when addressing concerns. Blatant stereotypes were often espoused. Such concerns as to the black resident's morality, cleanliness, and ignorance are readily viewable in the documents surveyed. In fact, the assumptions appeared to be so prevailing that it appeared as though they were considered common knowledge among the white health care leaders. Certainly, these stereotypes played a large part in the exclusion of black residents from the predominately white health care system. Critical race theory holds that racism is still prevalent in society and that it serves to promote the interests of whites. Evidence of overt racism was evident in the findings of this study. The interests of the black community often appeared to be ignored altogether and when the white community was forced to intervene with regards to the health and healthcare of black citizens they did so with reserve, and only to the degree needed to protect the white community's interests.

Louisville's black residents, being largely excluded from the predominately white health care system devised their own system. In fact, by the late 1800's the black community had, what appeared to be, a very healthy comparison to the white health care community. These institutions were important to the black community, especially while the community was being largely excluded from participating in the health care system of the white individuals. There developed a quality within those institutions that was personal. One of the oral history participants mentioned that individuals probably went to the Red Cross Hospital just like a Catholic might prefer a Catholic hospital or a Baptist might prefer a Baptist Hospital. Because it is documented that white hospitals excluded black patients, the presence of black institutions were far more important to the black

community.

It is unlikely that the stereotypes white providers held, historically, disappeared. There is nothing in the archive material that gave hint of any steps taken by the health care community to rid the system of these perceptions. Stereotypes must be challenged often if they are to be eliminated from an individual's mental repertoire (Schneider, 2004). This means that the health care community of the 1950's, the first to begin taking black patients, would have had to purposefully identify those stereotypes, and consciously find instances in which they could negate their relevance to the black patient. When societal norms changed to one of intolerance for such stereotypes, the health care leaders of that time likely continued to carry those stereotypes within their mental catalog. Those providers who continued to carry these beliefs, reflected these assumptions in their behavior and communication, and passed these along to others, creating transmission from generation to generation (Darity, Dietrich & Guilkey, 2001). Social psychologists warn that these preconceived stereotypes do not just go away once they are quieted from obvious view; they lie discreetly within the psyche and continue to carry weight in how we deal with other individuals. Their removal requires purposeful intervention to negate them (Dovidio, et al, 2005). There is nothing in the archival material to suggest that Louisville's healthcare providers intervened to negate the stereotypes that they held prior to desegregation.

CHAPTER 5 DISCUSSION

Understanding the Findings Using Critical Race Theory

This historiographical study focused on the black health care institutions or white institutions which served black residents in the city of Louisville, Kentucky. It was not conducted to be exhaustive to all possible documents and records. However, even within the specific focus of this study, Critical Race Theory was applicable. The primary tenets of CRT applied in this study are the notion that racism was pervasive within Louisville's society, that it was imbedded in the societal norms in a way that benefitted the white community, and that the collective black experience (in this case, of Louisville's black community) could speak to counter the collective white experience (in this case, Louisville's white health care system).

Racism pervasive in society

Certainly the data reveal that racism was indeed pervasive in Louisville society prior to integration. Black residents were characterized with negative attributes by white healthcare professionals throughout the years of a segregated system. They were consistently excluded from participating in most of the available healthcare institutions up to the integration of Louisville's healthcare system. Upon desegregation, although black residents were included, there is no evidence to support the notion that these healthcare leaders confronted the prior assumptions they held. Experts in social psychology will report that these assumptions do not disappear without serious effort to confront and negate them (Schneider, 2004) and can be passed from generation to

generation (Darity, et al., 2001).

Social justice activist Anne Braden (1999) argued that the desegregation legislature led to a covering over of the racist assumptions that fueled them. In doing so, white Americans (and in this case, healthcare providers) could tell themselves that all was well. In her 1999 epilogue to her book *The Wall Between*, Braden states the following:

...our movement killed Jim Crow; that is, we did indeed destroy segregation enforced by law. Doing so was no small accomplishment, one achieved by the blood and sacrifice of many people. But we found that, even after that, the evil still existed...and we came to realize that the process of integration, even desegregation, often failed because African Americans on the one hand, and whites on the other, had very different concepts of the struggle against segregation. To African Americans, this struggle sought freedom, dignity, liberation; for many whites, it meant people of color being absorbed into 'their' white world, which whites would still run. (Braden, 1999)

Embedded to benefit whites

This tenet of CRT was also supported by study findings. Several instances were identified where whites acknowledged a need to assist black Louisvillians in regards to health and healthcare but responsibility was constricted to that which kept the interest of white Louisville residents protected. Even when the walls of segregation were reluctantly removed, and black patients began to be admitted to white hospitals, it was ultimately in the interest of white healthcare providers (physician specialists) and not out of altruism.

Collective black experience challenges white experience

These opposing realities could be seen in the difference between recollections of oral history participants. Black participants were more likely to be specific about events regarding race in their recollections than were the white participants. Furthermore, the perspective of the white healthcare providers often contrasted that of the black patient. Two examples come to mind here. One was the surprise expressed by Breckinridge County Hospitals' administrator when he realized that the black community in Louisville was upset at the treatment (or lack of thereof) of the three black men injured in a car accident in Hardinsburg, Kentucky. The administrator had the perspective that the hospital had gone above and beyond, especially since it did not have a policy of admitting black patients. However, the perspective of the black residents in Louisville was that it was an egregious act of negligence. Another example can be seen in the case of Jewish Hospital's history book account of admitting black patients from 1958 forward. Although the statement was true, a document in Red Cross Hospital collection shows that the admission practice was very limited. So, Jewish Hospital's perspective (white perspective) was that the hospital was being fair; while the Red Cross Hospital perspective (black perspective) was that it was an inadequate attempt at fairness.

In following Ladson-Billings (1998) impression of CRT's purpose, the researcher using CRT has the goal of *deconstructing* the oppressive status, *reconstructing* in a way to appeal to humanity and *constructing* an equitable, socially just alternative. In this study, the true cause of segregation and integration of Louisville's health care system are exposed, *deconstructing* any assumptions that may be held regarding some altruism or misunderstanding of the intentions of Louisville's white health care providers in the past.

In *reconstructing* this information, these findings have demonstrated that the assumptions and attitudes the white health care providers held were never dealt with in a way to alleviate them. Thus, the findings suggest more research is needed to focus on this aspect of the health care disparity so that a *construction* of a more equitable health care system can occur.

Implications and Recommendations

The findings of this study add to the body of literature that seeks to explore and ameliorate the role of bias and stereotypes, attitudes and assumptions by health care providers and the health care disparity that exists for minority, especially black, patients in the U.S. The presented findings here suggest that the role these attitudes and assumptions played in continuing a segregated health care system were not properly addressed once the health care system integrated. According to experts on stereotypes, prejudice and bias these attitudes and assumptions do not simply disappear without serious effort. To dispose of a set of stereotypes, they must be challenged often and regularly with an opposite stereotype (Dovidio, Glick & Rudman, 2005; Schneider, 2004). This must start with acknowledgement that the stereotype exists. There is no indication that the white health care providers attempted to address those either. It is likely that these assumptions were passed from generation to generation (Darity, Dietrich & Guilkey, 2001) and may still be potential influences on unconscious perceptions of health care providers today.

This phenomenon is vital to address in alleviating racial disparities in healthcare. Many facilities have cultural diversity education but little has been done to assess their level of efficacy. Future studies assessing these education programs will be an important

step in identifying ways to counter negative assumptions held by healthcare providers. Such programs will need to provide purposeful counter-assumptions to those identified as being placed on individuals of varying race/ethnicity (Dovidio et al, 2005). Healthcare policy can then be guided by the results of these studies.

The nursing profession has the power to be on the forefront of such research and policy advocacy. Nurse researchers should be dedicating their efforts to identifying the types of cultural diversity education that remedies negative stereotypes or assumptions about others of different racial groups. This knowledge, applied to nursing practice and policy, will shape the future of healthcare and lead us closer to alleviate healthcare disparities.

Historical Research on Ethics

The study findings also revealed the importance of conducting historical research in a quest to understand ethical dilemmas in healthcare. The segregation of healthcare was an ethical dilemma which had a significant impact on an entire community's ability to pursue healthy and productive lives. There was at least one study that linked the prior assumptions applied to black Americans to the current assumptions of individuals receiving public health benefits (Steed, 2010). This application of old racial stereotypes to current "undesirables" needs further exploration.

In evaluating the reasons for exclusion of Louisville's black community from the predominately white health care system one can find themselves on the moral high ground. One might argue that the moral high ground, from which we, in the present, place judgment on the individuals of the past, is an unfair position from which to judge. It is thought that, in being of the enlightened generation, we have no ability to understand

or analyze the actions of the individuals of the past. That reasoning is a serious fallacy. Not only do we have our enlightened ability to make judgment of the past, we owe it to ourselves to do so. If Santayana (1998) is right, and those who fail to remember the past do, indeed, repeat it in some way. It is our responsibility to analyze the past for insight into our own present. Our judgment need not be to condemn the behaviors of individuals of the past, per se, but to learn from their mistakes. It could be easily argued that just looking into the past without intent to judge the behaviors of those of another generation is a disservice. By analyzing their mistakes and applying what we learned to similar situations of the present era, we can prevent history from repeating itself. This examination has significant implications for how current health care providers are taught, how services are evaluated and improved, and to what degree history can impact current and future health care research.

In the case of the white health care providers and leaders of the segregated health care system in Louisville, it is evident that they excluded black residents due to assumptions that they attributed to “undesirability”. This exclusion cost the black community in health and wellness over time. To this day, the black community lags behind the white in longevity, infant mortality and several disease states, all of which were pointed out at the beginning of this paper. What we can learn from the assumptions of those white health care providers and leaders, who were a product of their time, is that excluding individuals due to their perceived “undesirability” can lead to long-term health consequences. What we, the enlightened of this generation, must ask ourselves is, “Who might *we* be excluding?” If we truly ask ourselves this question, would it be clear that it is the “poor” or “uninsured” in which we exclude from participation in health care? We

might say, “That is just the way it is. If they do not have insurance, or cannot afford to pay, it is just part of the system of things”. However, we can compare that with the same assumptions that many white health care leaders had during integration: “It’s just the way it is; it’s the way of the system of things.” To ignore our enlightened ability to judge the assumptions we are making right now, especially in regards to the care and health of our patients within the healthcare system, is negligent.

Racialization of the Undesirable

In *Reproducing Race*, Khiara Bridges (2011), took an ethnographic approach to examine the public health experiences of pregnant women in New York City. As women in New York are eligible for state funded Medicaid services while pregnant, Bridges used the experiences of pregnant women receiving public health to understand racialization. Her findings, after eighteen months of interviews and observations of both the clinic and the public hospital through which these patients’ care were managed, was that the attributes that the predominately white health care providers applied to the patients were akin to the “welfare queen” popularized in the 1980’s. However, while the welfare queen was paired with the image of a black female, the “wiley patient” (as Bridges labels her) is seen as having no race. The “wiley patient” is in one instance uneducated and in need of being taught, but in the next instance considered a shrewd and cunning manipulator of the system. Furthermore, the “wiley patient” is seen as loose in her moral values and deceptive (Bridges, 2011). Although the “wiley patient” is not racialized, the attributes assigned to her are the same attributes that had been assigned to Louisville’s black residents during segregation: immoral, unethical and unintelligent. The negative attributes make the “wiley patient” undesirable. Bridges also found that in the case of the

women who were receiving public health, they were more likely to receive unnecessary, and sometimes intrusive, medical interventions than someone with private insurance. While being labeled as “high risk”, because of their impoverished background, they were subjected to such “extras” as STD checks at various points throughout the pregnancy (which private insured patients did not receive). Interestingly, one provider acknowledged that it was rare that the intrusive, late pregnancy STD screen revealed an actual infection (Bridges, 2011). One can wonder if there might be a system of paternal opportunism in this practice. While the providers likely feel that they are acting in the best interest of the patient, would they consider it such a necessity if there were no reimbursement as a potential incentive?

This is, in no way, meant to characterize the health care providers as focused only on the monetary bottom line. It is meant to point out the power of the influence of monetary gain. In a system such as the U.S. Health Care System, it is very easy to get lost in the original intent of health care which is to care for the health of others. As Stevens pointed out in *In Sickness and in Wealth*, once the nation began to see third-party insurance payers as the norm a spiral began:

Just as hospital insurance removed individual anxieties about paying large hospital bills, it removed considerations of cost constraints from hospital billings. Hospitals could pass increased costs on to insurers, who could pass them on again to millions of subscribers, sick and well, in small increases in hospital insurance premiums. The potential of a third-party payment system unleashed an unprecedented demand for hospital services. It was a demand that could be stimulated by the suppliers, that is, by the doctors and hospitals themselves.

Hospital expenditures and reimbursement mechanisms drove each other, in an expansionary spiral. (Stevens, 1989, p.257)

The individual patient is alarmingly left out of the “spiral” that Stevens describes. Only the health care provider (hospital, clinic or provider) battles the insurance party for which services are deemed necessary. The uninsured individual is increasingly left out of the equation. The patient is only entitled to the care that he or she is able to pay for out of pocket. In this system, the uninsured is excluded (through undesirability) and the publicly insured is given access but with a considerable amount of paternalism, and to some degree opportunism.

Bridges (2011) noted that it was as if there were two types of patient in the health care system, her “wiley patient” who received public health insurance and the privately insured patient (she did not include the uninsured at all). Furthermore, the “wiley patients” are “disqualified” from membership in the privileged group or whiteness, according to her, even when they may very well be white. Bridges builds her understanding of “whiteness” from an earlier work by Dorothy Roberts who identifies the contrasts of “whiteness” and “blackness” of women’s reproductive selves:

White childbearing is generally thought to be a beneficial activity: it brings personal joy and allows the nation to flourish. **Black** reproduction, on the other hand, is treated as a form of degeneracy. Black mothers are seen to corrupt the reproduction process at every stage... They damage their babies in the womb through their bad habits during pregnancy. Then they impart a deviant lifestyle to their children through their example. This damaging behavior on the part of

Black mothers—not arrangements of power—explains the persistence of Black poverty and marginality. (Roberts, 1997, p. 9)

Bridges argues that just because the notion of “race” is being taken out, the assumptions that have surrounded black reproduction are not necessarily buried. They are alive and well and now spread across a diversity of races all of whom are labeled “wiley” or those on public assistance. The image has not likely changed, one can still imagine the “welfare queen” when referring to the “wiley patient”.

While Bridges found the attributes of blacks formerly held to now be placed on the lot of public health insured patients in her ethnographic study, could a similar situation be happening in Louisville, Kentucky? Could there be displacement of once held racial stereotypes now superimposed on an entire sector of publicly insured patients? Further study is warranted in this area. Using Bridges (2011) ethnographic example, and the findings of this historiography, further investigation into the city’s indigent hospital’s social climate and attitudes of providers would be helpful in answering these questions. We know that historically, Louisville’s white health care providers and leaders felt that black patients were unethical, immoral, unclean, and deceptive. Might we find similar thoughts now applied to the indigent population irrespective of race?

Limitations of the Study

This study was limited to investigation of the health care system as it related to black Americans from an historical perspective in one U.S. southern border state city. Cities that lie deeper in the southern region of the United States likely have different historical stories as do those of the northern region. In addition, other minority groups may not share experiences similar to those who are the focus of the research.

Use of historical design provides a picture of past events and perspectives. The current health care system or current influences on care delivery to black Americans within this community, was not investigated. Although the researcher was constrained by the data that was available, all attempts were made to cross reference data to ensure accurate history. Some of these data sources may have been incomplete or fragmented. It is recommended that a more comprehensive historiography, while not necessary to shed light on the availability of care to African Americans in Louisville, would have been ideal and also provide a look at the parallel events of the white-only health care institutions would add depth to this historical health care study.

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Appendix A

Angela Calloway, PhD Candidate

University of Louisville

School of Nursing

Doctoral Dissertation Study

Interview Guide

Introduction: My research topic is the evolution of the health care for African Americans in Louisville. I am interested in learning more about the health care environment during the period of segregation. I would like to know how the city's health care institutions handled race on a daily basis. In addition, I am particularly interested in the process of integration of health care system. I would like to know more about how that took place in Louisville's health care facilities.

1. State your name, year you were born, and where you were born.
2. What was your role in the health care profession and when did you begin that role (what year)?
3. Please tell me where you were employed and the approximate dates you were employed there.
4. When you first entered the health care environment, what was your understanding of race in the health care system? Did you see black patients? Did you have black co-workers?
5. What event, or events, sticks out in your mind as representative of race relations within the health care system prior to segregation? After integration?
6. Were there any particular rules or policies regarding the care or admission of black patients at your facility?
7. As a black health care professional (where applicable), what were your experiences when entering the health care profession? What limitations did you experience?

Appendix B

**ORAL HISTORY CENTER
CONSENT FORM AND CERTIFICATE OF GIFT
University Archives and Records Center
University of Louisville
Louisville, KY 40292
502-852-6674**

I, _____, have been invited to participate in an oral history research interview sponsored by the Oral History Center of the University of Louisville, conducted by _____ on _____ at _____. The purpose of this interview is to record my memories of my experience with health care system in Louisville, Kentucky.

This interview will be conducted in the form of a guided conversation and will last approximately 90 minutes. I will be free to decline to answer any question that makes me uncomfortable. Moreover, I have the right to stop the recording at any time with no negative consequences. There are no foreseeable risks in doing this interview. The benefit of the interview is to the general public in the form of increased historical knowledge. I recognize that because the interview will be donated to the University of Louisville Archives there is no assumption of confidentiality, unless I expressly request it (which will be respected to the extent permitted by law).

We, the narrator and interviewer, do convey to the University of Louisville, its successors and assigns, the recordings of this interview as an unrestricted gift and also thereby transfer to the University of Louisville, all legal title, copyright, literary property rights, and all other rights, including transcription and publication rights, in the materials except as noted below. Furthermore, I, the narrator, voluntarily consent to the above. All of my questions have been answered and I understand I can have future questions answered as well. I have been given a copy of this form.

Restrictions, if any:

narrator date

interviewer date

The University of Louisville Archives and Records Center agrees to house, care for, and otherwise administer these materials in the best interest of impartial scholarship.

University Archivist

date

Any questions about this research should be directed to Tracy K Meyer, Department of History, 852-6817 or to Carrie Daniels, Oral History Center, 852-6674, or about this form should be directed to the University Human Studies Committee at 852-5188.

Appendix C

Table 4: List of patients and illnesses at Freedmen's Bureau Hospital

| <u>Age</u> <u>and</u> <u>Sex</u> | | <u>Admitting</u> <u>diagnosis</u> | | <u>Disease</u> <u>now</u> <u>existing</u> | | |
|--|----------|--------------------------------------|----|---|-----------------------------|------|
| 20 y.o. female | dementia | | | dementia | | |
| 17 y.o. male | | frostbite | | | scrofula * | |
| 22 y.o. male | | blindness | | | herpes simplex | |
| 36 y.o. female | | pthisis pulmonalis | ** | same | | |
| 36 y.o. male | | secondary syphilis | | general debility | | |
| 20 y.o. male | | gunshot wound | | ankylosis | | |
| 39 y.o. female | | pregnancy | | | chronic valvular disease | |
| 30 y.o. male | | mania | | | | same |
| 48 y.o. male | | paralysis | | | same | |

| | | | | | | |
|-------------------|--|-----------------------------|---------------------|----------------------|-----------------------------|--|
| 80 y.o. female | | rheumatism | | | same | |
| 24 y.o. female | | typhomalarial fever *** | prolapsed uterus | | | |
| 27 y.o. male | | dropsy of heart **** | | scrofula | | |
| 34 y.o. male | | fracture of fibula | | neuralgia herpes | | |
| 17 y.o. female | | pregnancy | | | debilitating indigestion | |
| 32 y.o. male | | perineal fistula | | febrile infection | | |
| 20 y.o. male | | cerebrospinal meningitis | same | | | |
| 2 y.o. female | | cholera | | | indigent/scrofula | |

*scrofula- tuberculosis infection of the lymph nodes

** phthis pulmonalis- a tuberculosis of the lungs with wasting of the body

***typhomalarial fever- typhoid fever

****dropsy of the heart-edema from heart failure



KentuckyOne Health™

November 7, 2012

Vicki Hines-Martin, PhD
Nursing Administration
Room 4055, Building K
Health Science Center
Louisville, KY 40202

RE: Chart Review

| | |
|--|---|
| JHSMH Study Number: <i>Please reference this # on all correspondence</i> | 062-12 |
| IRB Tracking Number: | 12.0357 |
| Project Title: | The evolution of black health care system in Louisville, KY |

Dear Dr. Hines-Martin,

The Jewish Hospital & St. Mary's HealthCare (JHSMH) Research Center has reviewed the documents you submitted on July 27, 2012 for the above referenced study. After review of this project it has been determined that you will not be interacting with any JHSMH staff or patients. Therefore JHSMH Final Institutional Approval (FIA) is not required.

Please contact us for any future research projects and feel free to contact Stephanie Copeland, RN, BSN Research Operations Manager, in the JHSMH Research Center at 502-210-4462 or email at StephanieCopeland@KentuckyOneHealth.org if you need additional information or have any questions.

Sincerely,

Beth MacCracken
Interim Director
JHSMH Research Center

JHSMH Research Center
2401 Terra Crossing Blvd., Suite 200
Louisville, KY 40245

10.24.2012

September 11, 2012

Vicki HinesMartin, PhD
Room 4055, Building K, HSC
Louisville, KY 40202

NHORA# 12-N0207 / IRB# 12.0357 / The evolution of black health care system in Louisville, Kentucky

Dear Dr. HinesMartin:

The Norton Healthcare Office of Research Administration (NHORA) is pleased to notify you that your application to conduct the above-mentioned research study in the following Norton Healthcare (NHC) facility has been approved.

- Norton Hospital

Please note: NHORA approval reflects permission to conduct the study within a Norton Healthcare facility from a regulatory and contractual perspective, and is independent of approval by the sponsor for initiation of the study. The sponsor or site may have additional requirements to address before the study can begin.

The following items must be submitted to the NHORA if your study continues to be conducted in a NHC facility and are applicable to your study:

- Annual Progress Report/Continuation Review form
- Annual Approval letters and current Informed Consent Forms approved by the IRB, if applicable
- Amendments and Amendment Approval letters
- Revised HIPAA documents such as revised Partial Waivers/Complete Waivers of authorization for each change in personnel
- Changes in the Conflict of Interest status
- Status: change of study, i.e. closed to enrollment, study termination etc.

To comply with HIPAA regulations:

- A copy of the Partial Waiver of Authorization must be filed with the medical record of every patient screened for the study, if applicable.
- For retrospective chart reviews, a copy of the Complete Waiver of Authorization must be filed with the medical record of every patient whose chart is reviewed for the study.
- Studies utilizing the HIPAA "Rule of 50" are exempt from these requirements.

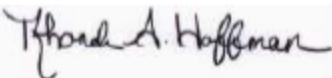
For studies utilizing an Informed Consent Form, a signed copy of the Informed Consent Form and Research Authorization must be filed with the medical record of each subject enrolled in your study in a NHC facility.

If applicable, the Research Patient ID form must be submitted to NHORA Finance daily with reportable activity. Please email the form to NHORAFinance@nortonhealthcare.org. Please contact Julie Gray at (502) 629-3565 for specific instructions regarding the notification of your subject enrollment at NHC.

We look forward to the successful completion of your study. If you have any further questions or need assistance, please contact the NHORA at (502) 629-3501.

Please let us know how we are doing. Follow the link https://www.surveymonkey.com/s/NHORA_satisfaction to complete the NHORA Satisfaction Survey in less than two minutes. Your feedback helps NHORA improve the services we provide and meet the needs of the research community.

Sincerely,



Rhonda Hoffman
System Director Research



INSTITUTIONAL REVIEW BOARDS

University of Louisville
MedCenter One, Suite 200
501 E. Broadway
Louisville, Kentucky 40202-1798

Office: 502-452-5188
Fax: 502-452-2184

To: HinesMartin, Vicki
From: The University of Louisville Institutional Review Board (IRB)
Date: Monday, September 10, 2012
Subject: Approval Letter

Tracking #: 12.0357
Title: The evolution of black health care system in Louisville, Kentucky.
Approval Date: 09/06/2012
Expiration Date: 09/05/2013

The revised document(s) for the above referenced study have been received and contain the changes requested in our letter of 08/02/2012. This study was reviewed on 09/06/2012 by the chair/vice chair of the Institutional Review Board (IRB) and approved through the Expedited Review Procedure, according to 45 CFR 46.110(b), since this study falls under Expedited Category (7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

The following items have been approved:

- Evolution of Healthcare in Louisville research project archive letter
- Evolution of health care in Louisville Interview guide
- Evolution of health care research project Participant recruitment letter, not dated
- Revised consent, dated 08/09/2012
- The Evolution of Health Care for Louisville's African American Community: 1865 to 1990 research proposal, not dated

This study now has final IRB approval from 09/06/2012 through 09/05/2013. You should complete and return the Progress Report/Continuation Request Form EIGHT weeks prior to this date in order to ensure that no lapse in approval occurs. The committee will be advised of this action at their next full board meeting.

Site Approval

If this study will take place at an affiliated research institution, such as Jewish Hospital/St Marys Hospital, Norton Healthcare, or University of Louisville Hospital, permission to use the site of the affiliated institution may be necessary before the research may begin. If this study will take place outside of the University of Louisville Campuses, permission from the organization should be obtained before the research may begin. Failure to obtain this permission may result in a delay in the start of your research.

Privacy & Encryption Statement

The University of Louisville's Privacy and Encryption Policy requires such information as identifiable medical and health records: credit card, bank account and other personal financial information; social security numbers; proprietary research data; dates of birth (when combined with name, address and/or phone numbers) to be encrypted. For additional information: <http://security.louisville.edu/PolStds/ISO/PS018.htm>.

1099 Information (If Applicable)

As a reminder, in compliance with University policies and Internal Revenue Service code, all payments (including checks, gift cards, and gift certificates) to research subjects must be reported to the University Controller's Office. Petty Cash payments must also be monitored by the issuing department and reported to the Controller's Office. Before issuing compensation, each research subject must complete a W-9 form.

For additional information, please contact the Controller's Office at 852-8237 or contro@louisville.edu.

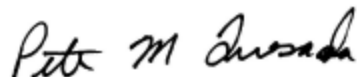
The following is a NEW link to an Instruction Sheet for BRAAN2 "How to Locate Stamped/Approved Documents in BRAAN2":

<http://louisville.edu/research/braan2/help/ApprovedDocs.pdf/view>

Please begin using your newly approved (stamped) document(s) at this time. The previous versions are no longer valid. If you need assistance in accessing any of the study documents, please feel free to contact our office at (502) 852-5188. You may also email our service account at hsppofc@louisville.edu for assistance.

Best wishes for a successful study. If you have any questions please contact the HSPPO at (502) 852-5188 or hsppofc@louisville.edu.

Thank you.



Board Designee: Quesada, Peter

Once you begin your human subject research the following regulations apply:

-
1. Unanticipated problems or serious adverse events encountered in this research study must be reported to the IRB within five (5) work days.
 2. Any modifications to the study protocol or informed consent form must be reviewed and approved by the IRB prior to implementation.
 3. You may not use a modified informed consent form until it has been approved and validated by the IRB.
 4. Please note that the IRB operates in accordance with laws and regulations of the United States and guidance provided by the Office of Human Research Protection (OHRP), the Food and Drug Administration (FDA), the Office of Civil Rights (OCR) and other Federal and State Agencies when applicable.
 5. You should complete and SUBMIT the Continuation Request Form eight weeks prior to this date in order to ensure that no lapse in approval occurs.

Letter Sent By: Burke, Rebecca, 9/10/2012 8:45 AM

*Full Accreditation since June 2005 by the Association for the Accreditation of
Human Research Protection Programs, Inc.*



CURRICULUM VITA

Angela Calloway RN, BSN
2337 Carlton Terrace
Louisville, KY 40205
(502) 409-7737
(502) 262-4373 cell
Akcall01@louisville.edu

Education

- 2009 PhD Candidate
 School of Nursing, University of Louisville, Louisville
- 2007 M.A., Pan African Studies
 School of Arts and Sciences, University of Louisville, Louisville
- 1993 B.S.N., Nursing
 School of Nursing, Indiana University Southeast, New Albany

Certifications & Licensure

Kentucky Registered Nurse, License #117565
Advanced Cardiac Life Support, 1995- present

Professional Employment

- 2010-current University of Louisville, School of Nursing, Clinical Instructor
- 2008-2010 Medical Staffing Network, School Nurse
- 2003 - 2008 Staff Nurse
 Norton Clinical Agency, Louisville
- 2003-2004 Clinical Research Coordinator
 Neurological Research Department, Department of Neurology,
 University of Louisville, Louisville
- 1999-2003 Staff Nurse
 StarMed Clinical Agency, Louisville
- 1994-1999 Commissioned Officer and Staff Nurse
 United States Air Force, Nurse Corps.

1993-1994 Staff Nurse
Norton Hospital, Louisville

Scholarship

Grants: Training

2006-2007 Graduate Assistant, University of Louisville School of Arts and Sciences. While being provided with tuition assistance and a monthly stipend, worked in the Ekstrom Library Archives Department sorting and compiling the paper and book collection of Anne Braden. Braden was a long-time social justice activist who resided in Louisville, KY.

2005-2006 Graduate Assistant, University of Louisville School of Arts and Sciences. While receiving a monthly stipend and tuition reimbursement, functioned as the teaching assistant to guest professor Anne Braden.

Grants: Research

American Nurse Foundation, Mary Elizabeth Carnegie Grant 2013.

University of Louisville, School of Interdisciplinary Graduate Studies, Dissertation Completion Award. Spring 2013.

Grants: Other

Publications

Calloway, A. (2005). Qualitative research for the development of evidenced-based intervention. *Kentucky Nurse*, 53, (2), 7.

Calloway, A. (2008). *A Pox Upon Healthcare: The Stereotypes, Prejudices and Biases of Healthcare Providers*. Germany: VDM Verlag.

Shawler, C., Edward, J.S., Ling, J., Wang, X., Stinson, K., Calloway, A., & Myers, J. (2012). Older Mothers with Hypertension and Adult Daughters: Health Related Quality of Life and Quality of Relationship. *Journal of Family Nursing* (In review)

Presentations

March 2013 School of Interdisciplinary Graduate Studies Symposium at the University of Louisville. 3 min presentation of "The Evolution of Healthcare for Louisville's African American Community: 1865-1990". Received first place award.

Professional Awards, Honors and Scholarships

Professional Organizations

Sigma Theta Tau

Physicians for a National Health Plan

Service

Professional Service

Community Service

2005-Present Member, Kentucky Alliance Against Racist and Political
Repression

University Service

2006 Intern for United States Commission on Civil Rights and the Dean of
Arts and Sciences, University of Louisville study of the academic
achievement gap between black and white students in Kentucky.

Teaching Experience

Graduate

Assistant Teacher: Social Justice Movements 1930-1965, Pan African Studies, University of
Louisville, Fall 2005.

Assistant Teacher: Social Justice Movements 1965-present, Pan African Studies, University of
Louisville, Spring 2006.

Clinical Nurse Instructor: Medical Surgical Nursing and Nursing Fundamentals, University of
Louisville, School of Nursing. August 2010-current.