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NEGRO HOSPITAL AND MEDICAL CARE FACILITIES IN NORTH CAROLINA

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I. Purpose

Increasing recognition in North Carolina of the importance of adequate hospital and medical care facilities and services for all the people has focused attention on the Negro population. The mere size of our Negro population is offered very often by many people as an all inclusive explanation of existing health and vitality conditions in the state. This is not necessarily true and often is not substantiated in fact. Yet, it is true that all the people, white and Negro, are becoming conscious of their medical needs and appreciate their importance to a sound society.

In accordance with this line of reasoning, the purposes of this report are: (1) To present a picture of existing Negro facilities and personnel in the state, such as doctors, hospital beds, hospitalization, dentists and nurses; (2) To show the results of such services as expressed directly in terms of infant mortality, maternal mortality, and the general death rate; and (3) To present some basic principles in organization of Negro facilities and personnel with the view of pointing the way for more adequate medical care services for all the people.

II. The Negro Population

This section of the report is not intended as a complete analysis of the Negro population in the state. Its purpose is only to indicate the scope of such population factors as are deemed to be directly related to the problem of medical care facilities for Negroes.

Size and Growth

In 1940 there were 981,298 Negroes in North Carolina; or, of each 1,000 persons, 275 of them were classified as Negroes.

The Negro population has been increasing in the state, but its percentage of the total population has been decreasing during the past eight decades. This is a very important fact and it should be fixed in the mind as there is a widespread general opinion that the Negro is increasing much faster than the white population.

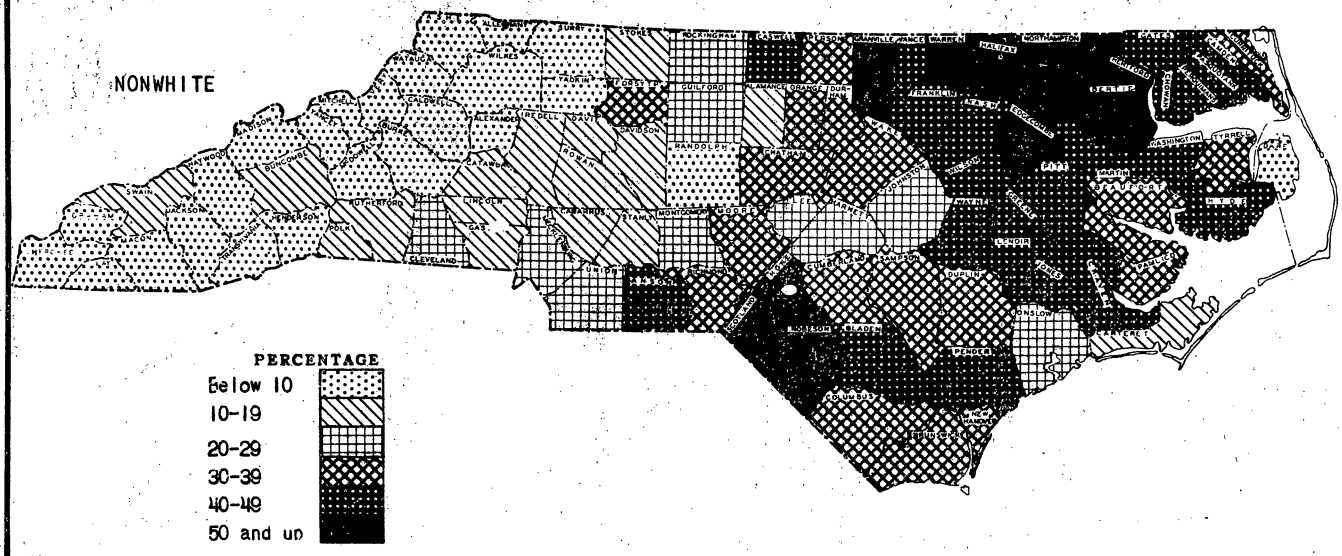
It is true that the Negro population has a high birth rate as shown by data for 1940: 101.6 live births per 1,000 females 15-44 years of age as compared with 85.4 for the white. Due, however, to a high mortality and migration, the Negro population increased only 6.8 per cent during the decade 1930-1940.

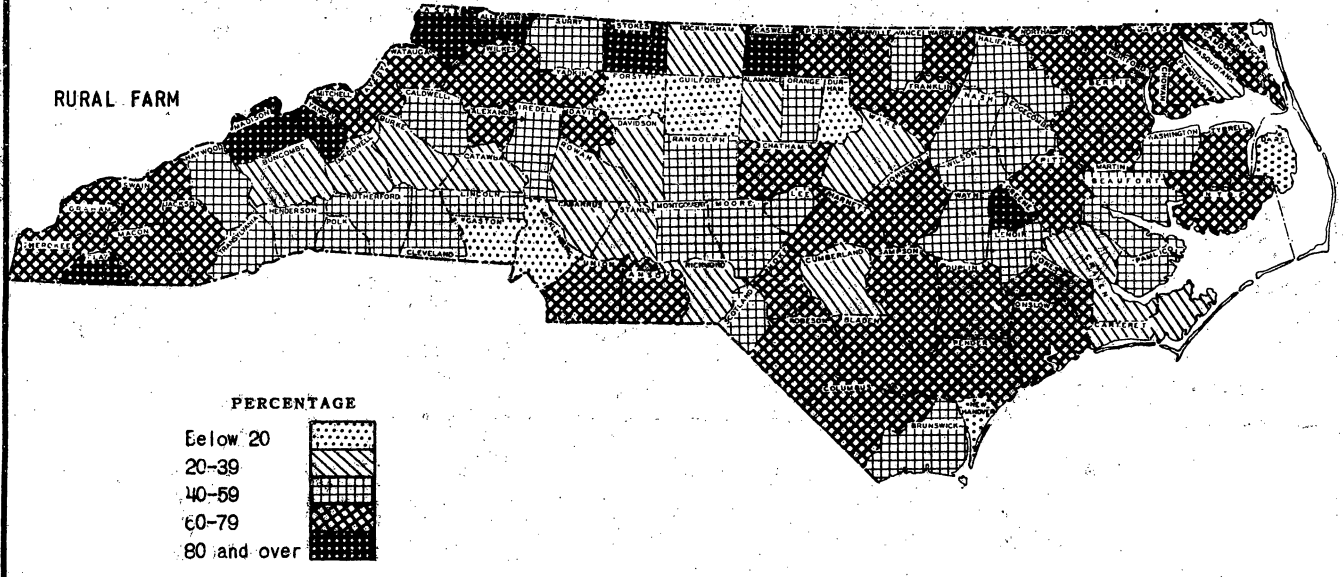
Residence

In analyzing a specific population or in comparing populations, perhaps no other factor in composition is as important as are differences in residence. Differences between rural and urban populations can go a long way in accounting for many other variations in the lives and problems of the people.

POPULATION BY COLOR AND RESIDENCE

North Carolina, 1940





N.C. Agricultural Experiment Station
DEPARTMENT OF RURAL SOCIOLOGY

Based on data from the U.S. Bureau of the Census

The following summary tabulation shows the number and percentage distribution of Negroes by residence as of 1940:

Residence	Number	Per Cent
Total	981,298	100.0
Urban	299,363	30.5
Rural	681,935	69.5
Nonfarm	201,853	20.6
Farm	480,082	48.9

A larger proportion of the Negro than white population is in urban centers of the state, and this has been the case since 1820. The Negro is very rapidly making some profound shifts in place of residence. During the decade 1930-1940, the number of Negroes in rural-farm areas decreased 17,414 or 3.5 per cent, but the urban population increased 53,126 or 21.6 per cent.

Occupation

The occupational composition of a population is significant because, to a great extent, it determines the economic status of the group.

In North Carolina in 1940, there were 332,359 Negroes, 14 years of age and over, gainfully employed, except on emergency work. The following summary tabulation shows the number and percentage distribution of such persons:

Occupation	Number	Per Cent
Total	332,359	100.0
Farm laborers and foremen	75,195	22.6
Domestic service workers	66,550	20.0
Farmers and farm managers	60,217	18.1
Laborers (except farm and mine)	47,117	14.2
Operative and kindred workers	33,535	10.1
Service workers	23,475	7.1
Professional and semi-professional workers	9,789	2.9
Craftsmen, foremen, and kindred workers	8,423	2.5
Clerical, sales, and kindred workers	2,583	0.8
Proprietors, managers, and officials	2,316	0.7
Protective service workers	681	0.2
Occupation not reported	2,478	0.7

These data above show in a very convincing manner the low economic status of the Negro. Remuneration for services rendered is extremely low in those occupations with the largest concentration of population. Laborers, including farm and domestic service workers, make up more than half, 56.8 per cent, of the gainfully employed persons, while professional and semi-professional workers constitute only 2.9 per cent.

Sex

The sex composition of a population is a significant factor in accounting for or explaining many behavior patterns of a given

group. Sex and age together very obviously determine the number of births and affect the crude general death rate and infant mortality. An unbalanced sex ratio will, to some extent in our society, determine who shall marry and who shall not; and, it may influence family life and sex behavior in general.

The sexes in the Negro population are unbalanced as shown in the following summary tabulation for 1940:

Residence	Males per 100 females
Total	95.7
Urban	84.2
Rural-nonfarm	96.4
Rural-farm	103.3

It is of interest to note that there is an excess of 25,751 females in the urban population and 7,802 excess males in the much larger rural-farm population. These differences should be recognized and their meaning thoroughly understood in analyzing and discussing any phase of Negro life in the state.

Age

The general age structure of a population may not appear to many people as being of any appreciable consequence to the understanding of the main problem. In most areas of society there are people of all ages - from the new-born infant to those who have lived a score or more years beyond the recognized span of life. However, differences in the age of populations will help to account for many other differences: crude death rate, productive population in relation to dependents, birth rate, marriage rate and a host of other factors.

The Negro population in North Carolina is younger than the white and the rural-farm population is much younger than the urban. The proportion of the population under 10 years of age is a good illustration: 15.9 per cent of the urban native white population is under 10 years as compared with more than a fourth - 27.4 per cent - of the rural-farm Negroes. The rural-farm Negro population is especially deficient in the productive years and this means a high dependency ratio.

Age	Urban		Rural-farm	
	Negro	Native white	Negro	Native white
Under 10	17.3	15.9	27.4	22.4
10-19	20.5	19.2	27.2	24.6
20-29	22.2	21.5	17.1	15.9
30-39	17.3	17.0	9.7	11.4
40-49	11.1	11.9	7.3	9.6
50-59	7.9	6.3	5.6	7.9
60-up	6.8	5.4	5.7	8.1

These age differences (1940) show clearly the type of most urgent medical care needs of the Negro population. A great deal of emphasis on education and facilities is needed in diseases peculiar to children and females in the child bearing ages.

III. Facilities and Services

Various types of medical care facilities and personnel - doctors, hospitals, dentists, nurses and public health - are not isolated units unto themselves. They fit into a pattern of medical services. Such a pattern is not complete, however, without two other elements: (1) Appreciation by the people for the need of good medical care; and (2) Ability of the people to pay for the necessary amount and quality of modern medical science. It is practically impossible to have one or two of these phases weak and the other strong; they will all be strong or all be weak. The pattern is either weak or strong, not weak and strong. In a comprehensive planning program, all three aspects must be approached as a single problem.

The Negro medical care problem in North Carolina is to a great extent a rural problem. A very large proportion of the people live in open country areas and in small population centers. Distance and relative isolation, low cash income, very low taxable wealth, poor communication and transportation facilities, poor public schools and many other such factors form a vicious crust through which it is particularly difficult to approach this problem. However, the necessity is paramount as the immediate and ultimate aim is human welfare and a better way of life for all the people.

Doctors

During the academic year 1938-39, only 1.64 per cent of the medical students in the United States were Negro students. Of these, 87 per cent were enrolled in two institutions - Howard University and Meharry Medical College. There is yet another discouraging aspect in this picture: the enrollment of Negro medical students showed a decrease from 1930 to 1939, but there was a slight increase during 1940. 1/

The decrease in Negro medical student enrollment was accompanied by a decrease in the number of Negro physicians in the United States. Actually, there were 175 fewer doctors in 1942 than in 1932. The decrease amounted to 4.6 per cent during the ten years, but the Negro population of the nation increased 8.2 per cent during the decade 1930-40. (Table 1).

Regional variations are very large and significant. The number of Negro doctors increased in the North but proportionately only about one-half as much as the population. Two of the areas of the North had an increase but in the other two areas the number decreased. The South and West were especially hard hit; all areas in both regions had fewer doctors in 1942 than a decade previously in spite of a sizable increase in population. (Table 1).

1/ Journal of the American Medical Association, Vol.116, No. 18, p. 2115; National Negro Health News, Vol 11, No. 1, January-March, 1943, pp. 3-5. For a summary of many items discussed in this report, see: Department of Rural Sociology, Medical Care Services in North Carolina, A Statistical and Graphic Summary, N. C. Agricultural Experiment Station, Progress Report No. RS-4, February, 1945.

Table 1.

Number of Negro Physicians and Percentage Change in Negro Population and Physicians, United States and Regions.

Region	Number of physicians		Percentage change	
	1942	1932	Population 1930-40	Physicians 1932-42
United States	3,810	3,985	8.2	- 4.6
North	1,700	1,582	15.8	7.5
New England	55	69	7.9	-20.3
Middle Atlantic	635	489	20.5	29.8
East North Central	705	746	14.9	- 5.5
West North Central	305	278	5.8	9.7
South	2,018	2,295	5.8	-12.1
South Atlantic	1,087	1,144	6.3	- 5.2
East South Central	538	626	4.6	-14.1
West South Central	393	525	6.3	-25.1
West	92	108	41.8	-14.8
Mountain	18	27	20.5	-33.3
Pacific	74	81	49.0	- 8.6

Source: Journal of the American Medical Association, Vol. 124, No. 13, March 25, 1944, p. 827.

States within the Southeast showed important changes in the number of Negro physicians during the decade 1932-42. In North Carolina, Negro doctors increased 45.3 per cent while in Arkansas the number decreased 45.8 per cent. These are the extremes and the other states fall within the limits. All the states of the Southeast except North Carolina and Alabama had a decrease.

In North Carolina by May 1944, the number of Negro doctors had decreased to 144 and 15 of these were not in active practice This means that the State had only 129 active Negro physicians, or 7,783 Negro people per Negro doctor. This, however, is only a part of the picture as many physicians are not totally effective for the general population.

There are many reasons that may prevent a doctor from being entirely effective. Age is one important factor. In a recent study, the number of effective practicing physicians was determined by reducing the number under 65 years of age by 5 per cent and those 65 and over by 66.7 per cent. 2/ If this technique were applied to the Negro doctors in North Carolina, the number of effective practicing physicians would be reduced by 20 or more, especially

2/ Robert L. McNamara, "Changes In the Characteristics and Number of Practicing Physicians in Rural Ohio, 1923-42," Rural Sociology, Vol. 9, No. 1, March, 1944, p. 12.

since it has been reported that the average age of Negro doctors in the state is now about 54 years.

Table 2.

Number of Negro Physicians, Percentage Change and Negro Population per Physician

State	Number		Percentage change	Population per physicians
	1942	1932		1942
North Carolina	170	117	45.3	5,772
Alabama	125	116	7.8	7,866
Virginia	183	185	- 1.1	3,614
Louisiana	98	116	-15.5	8,666
Kentucky	109	131	-16.8	1,964
Mississippi	58	71	-18.3	18,527
South Carolina	67	83	-19.3	12,152
Tennessee	246	308	-20.1	2,068
Florida	85	109	-22.0	6,049
Georgia	152	195	-22.1	7,134
Arkansas	58	107	-45.8	8,320

Source: Journal of the American Medical Association, Vol. 124, No. 13, March 25, 1944, p. 828.

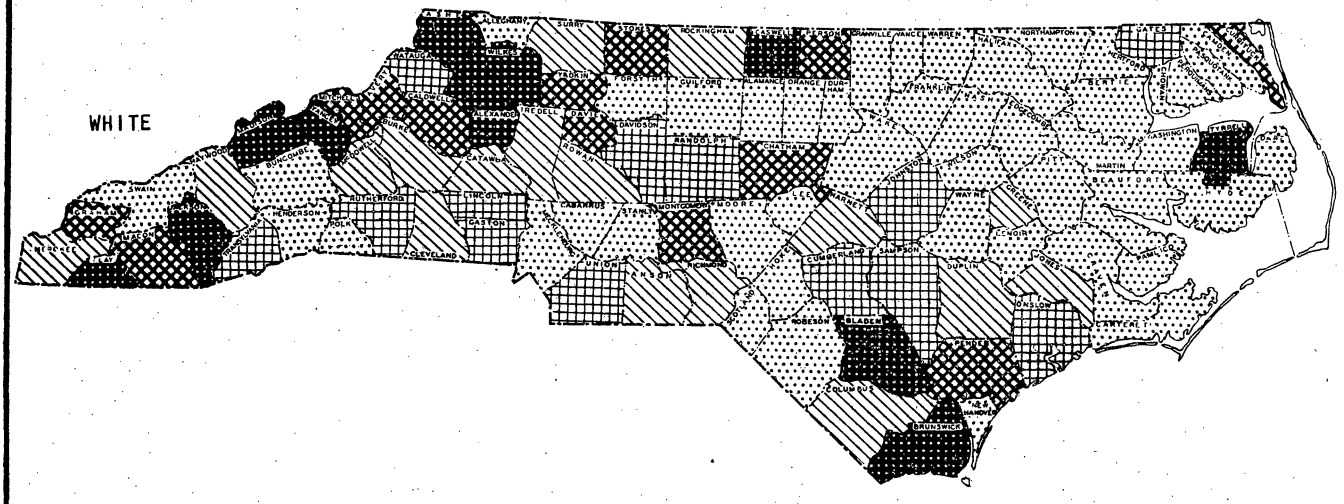
Other factors are important also. Efficiency of practice may be decreased by residential shifts of physicians. Other illustrations of this factor are numerous. In the state, one doctor is now employed by a business establishment and is out of general practice. Two Negro doctors specialize in eye, ear, nose and throat work and one is employed in the Public Health Department. If each case could be examined and studied very carefully, perhaps there are now no more than 100 effective Negro physicians in the state.

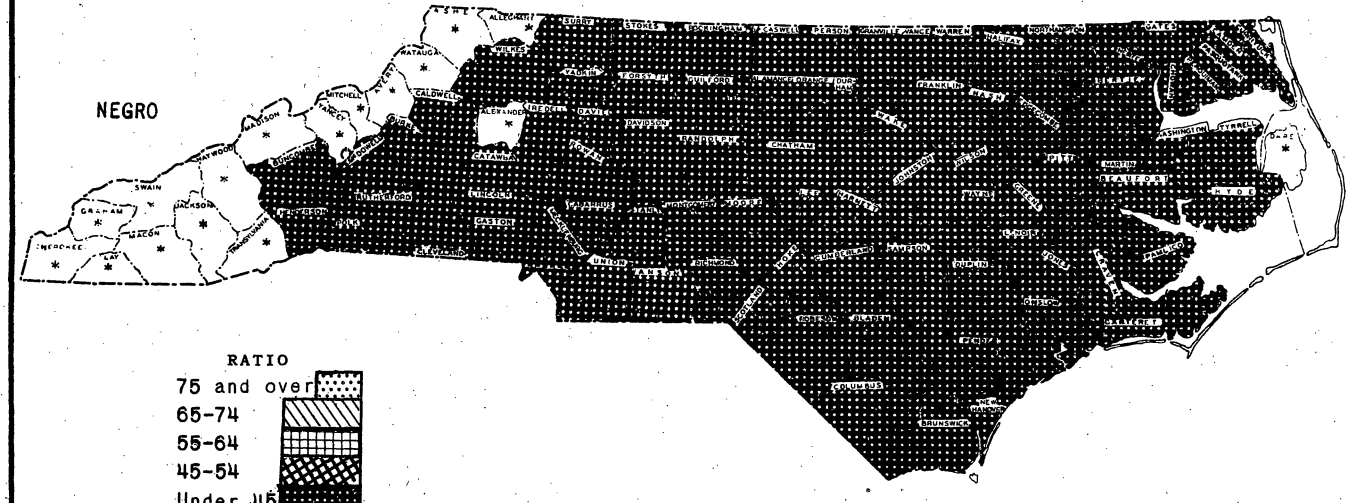
The usually accepted standard is one effective general practitioner per 1,000 population, and not merely one doctor for each 1,000 people. This, however, is only an average and does not reveal the whole story. One study made to determine the number of doctors necessary to care for a population, shows that a general physician can handle from 864 to 1,280 persons depending upon the amount of time given to preventive services.3/

Table 3 shows the county and population center in which 144 Negro doctors are located. There is at least one Negro physician in 48 of the 100 counties in the state. These doctors are located

3/ Samuel Bradbury, M. D., The Cost of Adequate Medical Care, The University of Chicago Press, Chicago, Illinois, 1937, pp.26-27.

PYHSICIANS PER 100,000 POPULATION
North Carolina, 1940





RATIO
75 and over
65-74
55-64
45-54
Under 45

* COUNTIES HAVING LESS THAN 1,000 NEGRO POPULATION

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BASED ON DATA FROM THE AMERICAN MEDICAL ASSOCIATION DIRECTORY

in 57 centers. The following summary tabulation shows a distribution of Negro doctors by the number in each center:

Doctors in a center	Number of centers	Number of doctors
Total	57	144
1	31	31
2	8	16
3	7	21
4	3	12
5	1	5
6-up	7	59

These data indicate a very uneven distribution of doctors. In fact, 21.5 per cent of the Negro physicians are located in 31 centers with one each and 59 of the doctors or 41 per cent are in 7 large urban centers.

Table 3.

Location and Number of Negro Physicians in North Carolina May, 1944.

County	Location	Number	County	Location	Number
State		144			
Alamance	Burlington	2	Iredell	Statesville	1
Anson	Wadesboro	1	Johnston	Smithfield	1
Buncombe	Asheville	6	Lenoir	Kinston	3
Beaufort	Belhaven	1	Mecklenburg	Charlotte	10
	Washington	1	Moore	Southern Pines	1
Bertie	Williamston	1	Nash	Rocky Mount	4
Chowan	Edenton	1	New Hanover	Wilmington	6
Cabarrus	Concord	2	Pasquotank	Elizabeth City	3
	Kannapolis	1	Northampton	Rich Square	1
Cumberland	Fayetteville	5	Pitt	Greenville	2
Craven	New Bern	4	Person	Roxboro	1
Columbus	Whiteville	2	Richmond	Hamlet	1
Caldwell	Lenoir	1		Rockingham	1
Durham	Durham	7	Robeson	Fairmont	1
Davidson	Lexington	1		Lumberton	1
	Thomasville	1	Rockingham	Reidsville	2
Edgecombe	Tarboro	2	Rowan	Salisbury	2
Franklin	Franklinton	1	Sampson	Clinton	1
Forsyth	Winston-Salem	15	Scotland	Laurinburg	1
Gaston	Gastonia	3	Union	Monroe	2
Guilford	Greensboro	8	Vance	Henderson	3
	High Point	5	Wayne	Goldsboro	3
Granville	Oxford	2		Mount Olive	1
Harnett	Dunn	1	Washington	Plymouth	1
Perquimans	Hertford	1	Wake	Fuquay Springs	1
Halifax	Enfield	1		Raleigh	7
	Weldon	1	Warren	Warrenton	1
Hoke	Sanatorium	1	Wilson	Wilson	3
			Wilkes	North Wilksboro	1

Source: Clyde Donnell, M. D., Durham, North Carolina

The following tabulation shows the distribution of Negro physicians by rural and urban areas and by size of urban center:

Size of Center	Number of centers	Number of doctors
Total	57	144
Rural	12 *	12 *
Urban	45	136
2,500- 4,999	12	14
5,000- 9,999	9	13
10,000-14,999	8	16
15,000-19,999	6	18
20,000-24,999	1	3
25,000-49,999	4	22
50,000-up	5	46

* Includes Kannapolis since it is unincorporated.

In 1940, 69.5 per cent of the Negro population was in rural areas but in 1944, only 8.3 per cent of the doctors were in rural areas. This means that 91.7 per cent of the doctors and only 30.5 per cent of the people were in urban centers. This does not tell the whole story of concentration: the five urban centers with more than 50,000 total population had only 12.3 per cent of the Negro population but had 31.9 per cent of the Negro doctors.

Hospital Facilities

Hospital facilities for Negro patients as measured by number of beds has been increased in North Carolina; and this is especially noticeable in areas where there has been a large influx of Negro laborers due to the war emergency. There are 1,760 hospital beds available for Negroes in 61 counties; still 39 counties without such services.

Negroes consume only about 15 per cent of the total days of hospital care in general hospitals of the state. A recent report of the Duke Foundation shows that during 1942, 53.5 per cent of the Negro and only 15.8 per cent of the white patient-days of care were free in 89 general hospitals in North Carolina. Thus for 1942, of each 100 patient-days of hospital care 22.5 were free to the patients.

There are still less than half enough beds for Negro patients, assuming that a way will be found to finance the cost of hospitalization so that the Negro population may receive the services required. The generally recognized standard is 4 beds per 1,000 people, but the present ratio is only 1.79 beds per 1,000 Negro people as compared with 2.72 for the white population.

The ratio is already above 4 in 13 counties; several of these counties are in the extreme western part of the state where the number of Negroes is very small. Most of the other counties have large urban centers where philanthropic and church bodies

have been of tremendous influence. It is of interest to note that the Negro ratio is higher than the white in 12 of these 13 counties. In fact, the Negro ratio is higher than the white in 22 of the 61 counties but lower in the other 39. (Table 4). This appears to indicate that in those counties with few facilities for the white population, Negroes have even fewer facilities; the total population must be the measuring rod.

Table 4.

Hospital Beds for Negroes per 1,000 Negro Population, * North Carolina, 1944.

County	Number of beds	Ratio per 1,000 population	Negro ratio higher or lower than white
State	1,760	1.79	Lower
Macon	6	12.90	Higher
Cherokee	2	10.99	Higher
New Hanover	164	9.61	Higher
Avery	2	7.72	Higher
Forsyth	279	6.78	Higher
Haywood	6	6.73	Higher
Surry	16	6.32	Higher
Transylvania	5	5.95	Higher
Durham	164	5.75	Lower
Burke	16	5.05	Higher
Stanly	18	4.60	Higher
Henderson	9	4.22	Higher
Craven	59	4.20	Higher
Wake	110	2.99	Lower
McDowell	5	2.73	Higher
Catawba	13	2.52	Lower
Vance	35	2.51	Lower
Tyrrell	5	2.49	Lower
Cabarrus	24	2.46	Higher
Polk	4	2.43	Higher
Guilford	75	2.33	Lower
Cumberland	46	2.28	Lower
Lee	12	2.24	Lower
Ashe	1	2.11	Higher
Nash	48	2.06	Lower
Mecklenburg	87	2.01	Lower
Robeson	50	1.96	Lower
Cleveland	25	1.95	Higher
Wilson	41	1.95	Lower
Buncombe	31	1.92	Lower
Iredell	18	1.88	Lower
Carteret	5	1.85	Lower
Onslow	9	1.85	Lower
Randolph	8	1.85	Higher
Lincoln	6	1.82	Lower
Moore	17	1.82	Lower
Jackson	1	1.78	Higher

Continued.

Table 4 Continued.

County	Number of beds	Ratio per 1,000 population	Negro ratio higher or lower than white
Gaston	22	1.75	Higher
Brunswick	10	1.73	Lower
Rockingham	20	1.66	Lower
Richmond	20	1.64	Lower
Rutherford	10	1.63	Higher
Lenoir	28	1.57	Lower
Rowan	20	1.54	Lower
Davidson	9	1.53	Higher
Caldwell	4	1.49	Lower
Wilkes	4	1.42	Lower
Wayne	33	1.30	Lower
Harnett	14	1.17	Lower
Anson	16	1.15	Lower
Granville	16	1.07	Lower
Beaufort	14	1.01	Lower
Columbus	13	.91	Lower
Union	8	.87	Lower
Pasquotank	7	.80	Lower
Halifax	23	.72	Lower
Scotland	8	.69	Lower
Alamance	6	.57	Lower
Edgecombe	15	.56	Lower
Pitt	14	.48	Lower
Martin	4	.32	Lower

* Population as enumerated in 1940.

Source: Number of beds compiled by Alexander Webb of the Hospital and Medical Care Commission.

There are five counties with hospital facilities for the white population but none for Negroes - Chatham, Johnston, Person, Sampson and Swain. In 1940, there were more than 47,000 Negroes in the five counties; however, in fairness it should be stated that none of these five counties have enough beds for the white population.

Of the 1,760 general hospital beds for Negroes in North Carolina, 879 or 49.9 per cent are located in six counties with large urban centers. The concentration is greater than this indicates, as 34.5 per cent of the beds are located in three counties-Forsyth, Durham, and New Hanover.

There are 13 general hospitals exclusively for Negroes in the state. Their location, size and business for 1943 are shown in Table 5. Measured by average census, 63.8 per cent of the beds were occupied daily. This is compared to 70.3 per cent for the nation in 1940 and 66.8 per cent in the eleven states of the Southeast. The corresponding percentage for North Carolina in 1940 was 60.8. Due, perhaps, to the increasing economic ability of the population since 1940 to pay for hospital services, a larger proportion

of the hospital beds are being occupied as shown by the fact that 68.5 per cent of all beds in North Carolina were occupied in 1943. A study of 88 general hospitals for Negroes in 1939 throughout the nation showed 62.2 per cent occupancy. 4/ So, the rate of occupancy of existing Negro facilities appears to be lower than that of white facilities.

Another important measure of hospitalization is the average length of stay by patients. For the nation in 1940, patients admitted to hospitals stayed on the average 12.9 days as compared to 11.9 days in the Southeast. For North Carolina in 1940, the average was 15.6 days per patient admitted. For the 13 Negro general hospitals in 1943 the patients remained on an average of 11.1 days as compared with only 8.6 days for all hospital patients in the state. In the study mentioned previously of 88 Negro general hospitals, in 1939, patients remained an average of 13.9 days. 5/ All of these data summarized indicate that more patients are going to the hospital but are remaining for shorter periods. They indicate further that Negroes still can not afford luxury service, but only the most serious cases of illness and accidents go to hospitals and therefore have to remain for longer periods of time.

A report just released by the American Medical Association shows that during 1944, the rate of occupancy dropped sharply to 59.2 per cent and the average length of stay also decreased to 10.8 days in the Negro hospitals in the state.

Table 5.

General Hospitals for Negroes, North Carolina, 1943

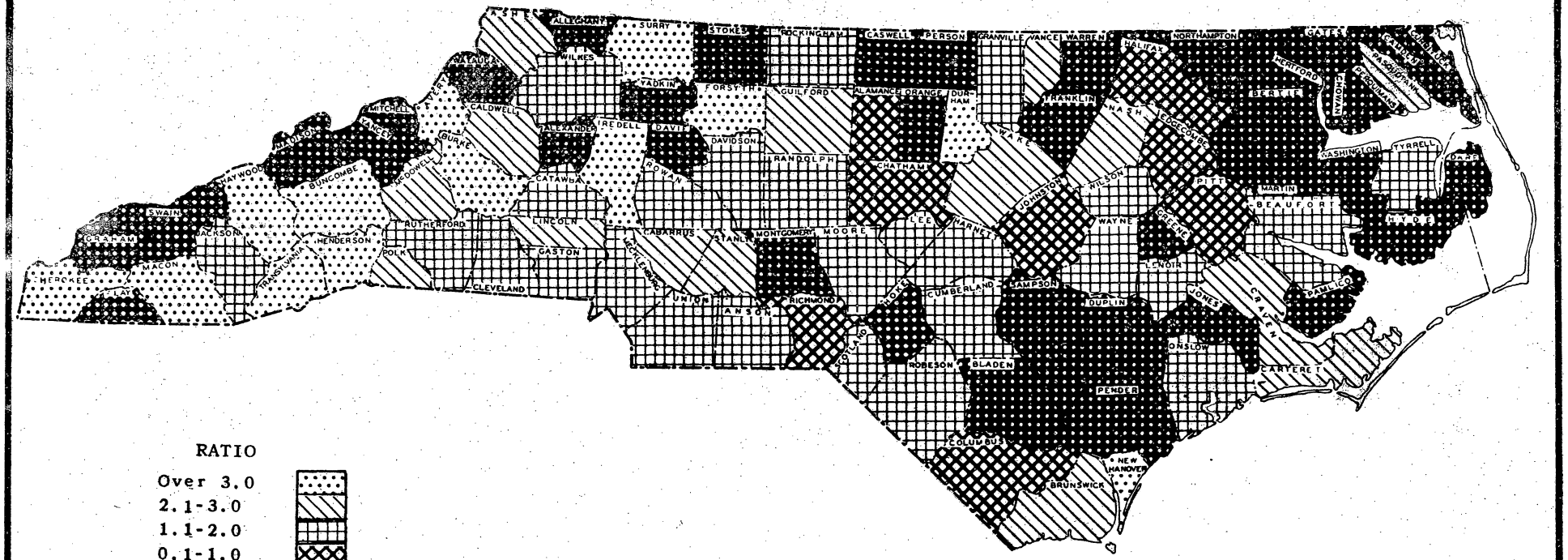
Name of hospital	Location	Number of beds	Average census *	Admissions *	Per cent occupied	Length of stay in days
Asheville Colored	Asheville		(Data not available)			
Good Samaritan	Charlotte	87	68	2,098	78.2	11.8
Lincoln	Durham	99	67	1,926	67.7	12.7
Gaston County	Gastonia	22	9	317	40.9	10.4
L. Richardson	Greensboro	60	35	1,103	58.3	11.6
Jubilee	Henderson	30	24	584	80.0	15.0
Good Shepherd **	New Bern	30	19	702	63.3	9.9
Susie C. Cheatham	Oxford	16	11	486	68.8	8.3
McCauley	Raleigh	10	5	129	50.0	14.1
St. Agnes	Raleigh	100	60	2,103	60.0	10.4
Community ***	Wilmington	49	51	2,144	104.1	8.7
Mercy	Wilson	41	18	514	43.9	12.8
Kate Reynolds****	Winston-Salem	201	108	2,588	53.7	15.2

* Exclusive of newborn infants.
** Bed capacity has been increased to 55.
*** Capacity increased to 125.
**** 1944 data.

Source: Journal of the American Medical Association, Vol. 124, No. 13, March 25, 1944, pp. 893-895.

4/ Journal of the American Medical Association, Vol. 115, No. 17, p. 1461.
5/ Ibid.

HOSPITAL BEDS FOR NEGROES PER 1,000 NEGRO POPULATION
North Carolina, 1943



RATIO

Over 3.0	
2.1-3.0	
1.1-2.0	
0.1-1.0	
No beds	

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Based on data from Duke Endowment Hospital Statistics

Modern hospitals perform functions other than caring for sick people. Two of the 13 Negro general hospitals are approved for the training of interns by the Council on Medical Education and Hospitals; these are Lincoln and St. Agnes. Six of the general hospitals are approved as schools of nursing and are accredited by by the State Board of Nurse Examiners. Lincoln, L. Richardson, St. Agnes and Kate Reynolds are approved by the American College of Surgeons as meeting unconditionally its minimum standards.

Dentists

According to the 1940 Census there were 59 Negro dentists in North Carolina but by 1944-45 this number had increased to 74 including those employed in public health work, distributed as shown in Table 6.

North Carolina has less than one-tenth as many Negro dentists as needed to serve the approximately one million Negroes in the state. A recommended optimum dentists-patient ratio is 98 per 100,000 population with the assistance of hygienists for scaling and cleansing. 6/ Even this assumes, perhaps, that most teeth and gums are in better condition than is actually the case now.

In 1940, there were 12 nonwhite dentists per 100,000 nonwhite population in the United States, as compared with 58 for the white population. In North Carolina, the ratos were 6 for the Negro population and 28 for the white. Even with 74 dentists, the rate is only 7.5 per 100,000 population. In any case, North Carolina ranks too near the bottom among the states.

The 74 dentists are located in 30 communities in 29 counties. Only one of these is located among the rural population and urban centers have the remainder. 7/ The five urban centers with 50,000 or more population has 29 or 39.2 per cent of all Negro dentists.

Table 6.

Location and Number of Negro Dentists in North Carolina 1944-1945

County	Location	Number
State		74
Alamance	Burlington	1
Beaufort	Washington	1
Buncombe	Asheville	5
Chowan	Edenton	1
Cumberland	Fayetteville	1
Durham	Durham	5
Forsyth	Winston-Salem	9
Granville	Oxford	1
Guilford	Greensboro	4
	High Point	3

6/ Samuel Bradbury, op. cit., p. 51

7/ This is somewhat exaggerated as these figures include those dentists employed by the public health department on a state wide basis.

Table 6 Continued.

County	Location	Number
Halifax	Weldon	1
Iredell	Statesville	1
Lenoir	Kinston	1
Mecklenburg	Charlotte	6
Nash-Edgecombe	Rocky Mount	3
New Hanover	Wilmington	3
Orange	Chapel Hill	1
Pasquotank	Elizabeth City	2
Pitt	Greenville	1
Richmond	Hamlet	1
Robeson	Lumberton	1
Rockingham	Reidsville	2
Rowan	Salisbury	2
Sampson	Clinton	1
Scotland	Laurinburg	1
Union	Monroe	1
Vance	Henderson	2
Wake	Raleigh *	9
Wayne	Goldsboro	2
Wilson	Wilson	2

* Includes those employed by the State Board of Health.

Source: Program of the Fifty-Seventh Annual Meeting, Medical, Dental, and Pharmaceutical Society, Inc., June, 1944, pp. 21-22; and C. M. Walker, Assistant Administrator, St. Agnes Hospital, Raleigh, N. C.

Nurses

According to the census of 1940, there were only 460 Negro trained nurses and student nurses in North Carolina. This is a ratio of about 47 per 100,000 Negro people. This is very low as compared with 316 in Montana and 278 in New York for the total non-white population. On the other hand, the ratio is high as compared with 12 for Mississippi, 13 in Arkansas and 14 in Louisiana. In 1940 there were 226 white trained and student nurses per 100,000 white population and this was low as compared with 494 in Massachusetts, 452 in Connecticut and 295 for the entire nation.

There are seven hospitals in the state approved for the training of nurses - six general hospitals and one mental institution. The following summary tabulation shows the name of the hospital and the number of student nurses graduated in 1941 and 1944 exclusive of the Cadet Nurse program:

Hospital	Number Graduated	
	1941	1944
Total	55	83
Good Samaritan	8	14
Lincoln	11	14
L. Richardson	8	4
St. Agnes	12	16
Community	-	6
Kate B. Reynolds	13	16
N. C. Sanatorium	3	13

Nurses graduated from the N. C. Sanatorium receive one year of general training at Kate B. Reynolds and then transfer to the state institution.

In 1941, 61 Negro students passed the state nurses examination and became registered nurses and in 1944 the corresponding number was 83. Many students graduated from the schools qualified to train nurses do not pass the state examination on the first attempt; however, there are enough repeaters who do pass the examination that the number of graduates from schools and the number registered are very nearly the same each year in North Carolina.

Many Negro nurses trained in North Carolina who pass the state examination go to other states to practice in spite of the fact that the state does not have enough Negro nurses to meet any sort of minimum standard. The usually accepted explanation for this situation is that the remuneration for services rendered is too low as compared with that received in large cities in states farther up the Atlantic coast.

There is no salary differential between white and Negro nurses in those cities. In North Carolina some hospitals that care for both white and Negro patients employ Negro nurses for their Negro patients, but there seems to be a considerable pay scale differential between white and Negro nurses in the same hospital.

Public Health Personnel

The Negro public health personnel at the state level consists of one full-time doctor, one nurse and one nutritionist. The nurse and nutritionist are assigned to counties for a limited period to give assistance in special school programs.

Prior to the war, 19 Negro doctors were employed on a part-time basis to assist with the maternal and venereal disease clinics. Now, however, the number is down to about half the pre-war level.

Before the war, there were seven Negro dentists employed in public health work on a state wide basis, but that number is now down to four.

There are 43 Negro nurses employed in public health work on the county and city levels in the state. These nurses are located in the following districts, counties and cities:

Anson and Montgomery	1	Orange, Person and Chatham	1
Cabarrus	1	Pitt	1
Craven	1	Vance	1
Cumberland	1	Wake	3
Durham	4	Wilson	1
Edgecombe and Halifax	3	Asheville City	1
Forsyth, Stokes, Yadkin, and Davie	2	Charlotte City	6
Gastonia	1	Greensboro City	6
Lenoir	1	High Point City	1
New Hanover	3	Rocky Mount City	1
		Winston-Salem City	3

There is no Negro public health personnel in the other districts, counties and cities. It should be noted that 18 or nearly 42 per cent of the Negro nurses are employed by and serve the people in six large urban centers, but only 11.8 per cent of the Negro people live in those cities.

IV. Results of Inadequate Medical Facilities and Personnel

The direct results of inadequate facilities and personnel for the Negro population may be measured in many ways: poor medical care and poor health, and these in turn may be measured in terms of human suffering and misery; low productive manpower; loss of life; lowered income and tax revenue; and the army uses the standard of percentage of registrants rejected for military service. On the other hand, the measuring stick may be infant mortality, maternal mortality, or the general death rate. Regardless of the measure used, the results are identical.

Infant Mortality

Infant mortality rate is one of the most, if not the most sensitive of all indexes of the adequacy of medical care facilities and services. The standards of a society may be judged by this factor for as one doctor has said: "The sanitary, social, and economic status of a people is reflected in their infant mortality." 8/

Negroes have a high birth rate, but this is accompanied by an exceedingly high infant mortality rate. In 1942 there were 63.7 Negro infant deaths per 1,000 live births in North Carolina as compared with 41.4 for the white population. Even this is high as the white rate for the entire nation was down to only 37.3. It is of interest to note that the Negro rate in North Carolina is lower than the corresponding nonwhite rate for the nation but the U. S. white rate is lower than in the state. These rates for the state and nation represent a rather steady decrease for a number of years; however, much is yet to be accomplished as many groups have lowered their rates to around 25 and even lower.

The number of stillbirths is also a reflection of medical care facilities and the knowledge of the principles of healthy living. In 1940, there were 120 Negro infant deaths and stillbirths per 1,000 births in North Carolina as compared with 74 for the white population. The corresponding ratios for the United States were 69 for the white and 123 for the nonwhite population.

In 1940, the urban infant mortality rate was slightly lower than the rural in North Carolina. However, among Negroes the urban rate was 23 per cent higher than the rural, but among whites the urban rate was 14 per cent lower than the rural. The following should be carefully noted: as the size of urban centers increases, the number of Negro infant deaths per 1,000 live births also increases; but, the very opposite of this appears to be the pattern for the white population. This is a direct reflection of poor

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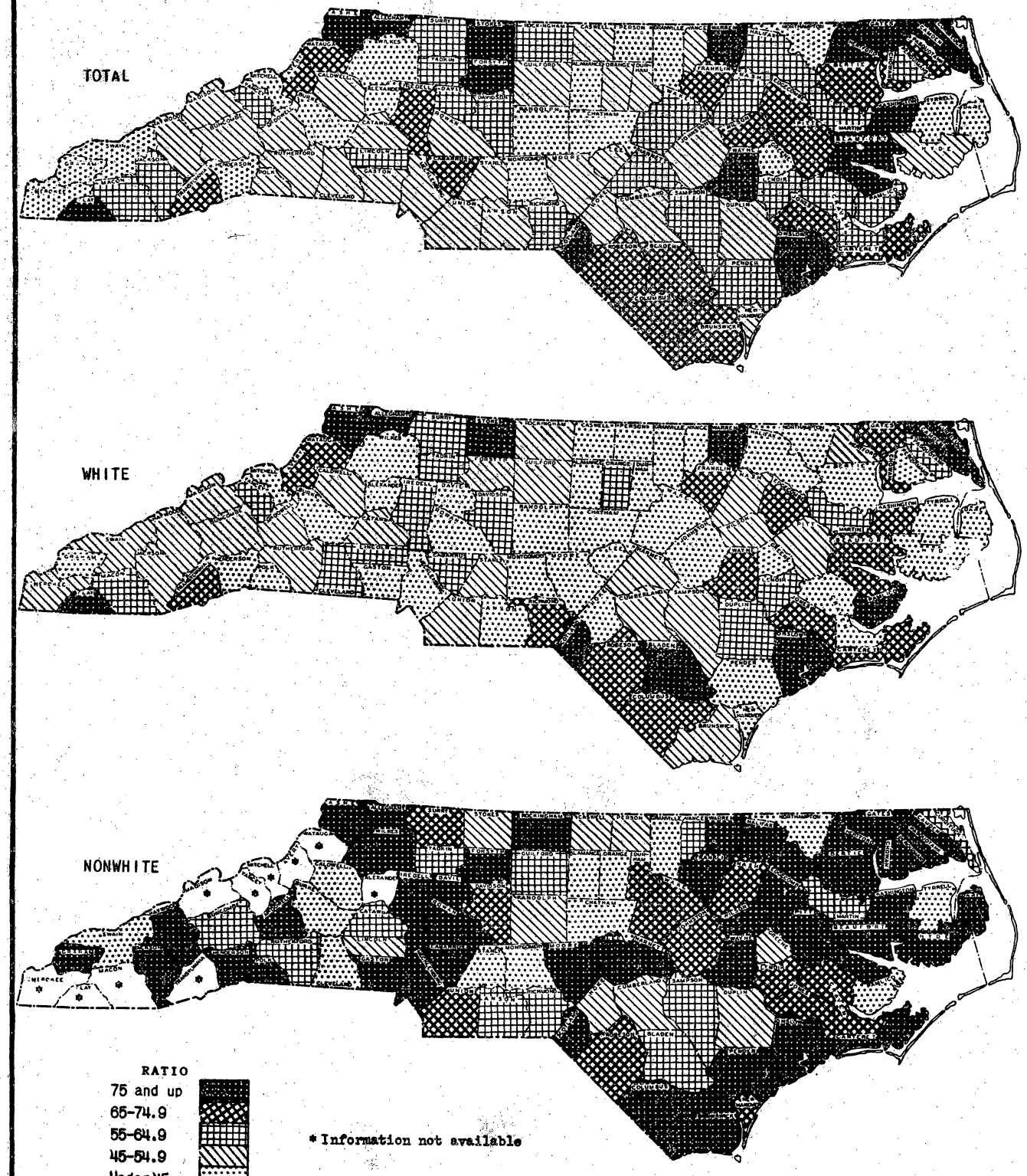
8/ Walter J. Hughes, M. D., "The Particular Needs of Negroes," address delivered at State-wide Conference on Better Care for Mothers and Babies, Raleigh, N. C. February 15, 1939.

INFANT DEATHS PER 1,000 LIVE BIRTHS
North Carolina, 1940



N.C. Agricultural Experiment Station
DEPARTMENT OF RURAL SOCIOLOGY

BASED ON DATA FROM U.S. BUREAU OF THE CENSUS

housing and over crowding, poor sanitation, and the extremely low economic and social conditions of Negroes in urban centers.

High infant Negro mortality is to some extent understandable when cognizance is taken of the fact that only 28.9 per cent of all Negro live births in the United States occur in hospitals. Nearly three-fourths (72.7 per cent) of the white births occur in hospitals. The picture for North Carolina is even more startling: only 13.6 per cent of the Negro births occur in hospitals.

Only 6.1 per cent of the white babies but 54 per cent of the Negro babies do not have a doctor in attendance at birth. In this respect, North Carolina makes a very poor showing and is very near the bottom among the states. Since most of the existing hospitals and doctors are in urban centers, rural people do not have access to adequate facilities and services. If adequate physical facilities were in rural areas, the problem of paying for necessary services would still exist.

Maternal Mortality

The number of Negro maternal deaths is not large but an analysis is important for two reasons: (1) Maternal mortality is another important index of society and amount of medical care facilities available to a population class; and (2) It is generally agreed that under proper supervision and adequate facilities no mother need die due to child birth.

In 1940 there were 7.6 Negro maternal deaths per 1,000 live births in North Carolina as compared with only four in the white population. However, the rate was only 3.2 for the total white population in the nation. The Negro rate for the state was slightly lower than the nonwhite rate in the nation. Urban centers with populations of from 2,500 to 10,000 are the real danger areas for Negro mothers in the nation but they are especially hazardous in North Carolina. In these centers there are 18.5 Negro maternal deaths per 1,000 live births in the state and the rate is 10.2 for the nonwhite population in the nation. The rate in rural areas is generally lower than in urban centers of the state. The really bright part of this picture is that the rate is going down and in some states the rate is now almost negligible. For example, in 1940 the rural rate was only 1.5 in North Dakota as compared with 12 for the total Negro population in Delaware.

It is rather difficult to assign specific responsibility for maternal deaths; however, if none need occur the blame must be assigned. On the basis of a careful analysis of 97 Negro maternal deaths in the South, Dr. James R. McCord assigned the immediate responsibility for these preventable deaths as follows: (1) hospital doctor, 37 per cent; (2) the patient, 37 per cent; (3) hospital routine, 12 per cent; (4) outside doctor, 10 per cent; and (5) midwife, 4 per cent.9/ These data are significant but they must be interpreted with care as the study is evidently too heavily weighted with cases which occured in hospitals.

One important fact is often overlooked in the study of maternal mortality: except for a few multiple births, the number of

9/ Journal of the American Medical Association, Vol. 116, No. 23, June 7, 1941, p. 2600.

babies born without hospital facilities or without a doctor attendant is accompanied by a like number of mothers without these same facilities and services. More than half (54 per cent) of the Negro mothers in North Carolina have no medical attendant at childbirth.

The General Death Rate

The rate at which people die has been decreasing, on the average, in the United States and North Carolina, and for both the white and Negro population. The result is now that people at most ages can expect to live much longer than in former years. Much of this increased life expectancy is due to the decrease in the rate at which infants die. It is important to analyze the Negro death rate because it is another significant and sensitive index of a cultural complex of a society and of the behavior patterns of specific groups within the total society.

North Carolina has a low crude death rate and, in fact, only four states had a lower crude death rate in 1940. This, however, has told us very little because North Carolina also has a very young population as compared with several other states and the Negro population is younger than the white. If valid comparisons are to be made between two or more populations or two or more segments of the same population, only adjusted death rates from which age (in some cases, other factors) bias has been eliminated should be used.

In 1940, the adjusted [10/] Negro mortality rate in North Carolina per 1,000 population was nearly twice as high as for the white population - 12.25 and 6.72 respectively. Both of these rates were lower than corresponding rates in the nation. The rural death rate is generally lower than the urban; but, just as important is the fact that the urban rate is decreasing faster than the rural. The natural advantages of the rural environment are rapidly being surpassed by excellent facilities and planned programs in urban centers. With proper planning and cooperation among all levels of interest - local community, county, state and national - more adequate facilities and services as well as personnel can be made available for the use of rural people throughout the length and breadth of North Carolina.

A very large proportion of the deaths among Negroes are preventable. In 1940, 11,647 Negro residents died, but if the rate had been as low as for the white population in the state there would have been 4,456 or 38.3 per cent fewer deaths. This, however, represents only about one-half the saving of life that could reasonably be expected: 7,694 or 66.1 per cent of the deaths would not have occurred if the death rates were as low as in the best age group already existing among the states of the nation. Even this is not the total picture because many communities and population groups now have rates much lower than those used as a basis for obtaining these results.

Table 7 shows the number of deaths that could be saved in each age group if the Negro death rate were as low as in these

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10/ Adjusted to the age distribution of the total United States population and excluding age groups under one and 75 years and up.

specified populations. The lives saved would be greatest in the most productive years of life - 15 to 54 years of age. Unnecessary and preventable deaths are so expensive that local communities, the state and the nation cannot afford further delay in making it possible for all the people, anywhere and everywhere and especially our rural people, to have available medical care facilities and an equitable method for purchasing needed services.

Table 7.

Number of Negro Deaths, Number of Deaths if Other Rates Prevailed and Percentage Change with Other Rates by Age Groups, North Carolina, 1940.

Age group	Deaths	Deaths if rates were as:		Percentage change if rates were as:	
		White, N.C.	White, best age group in nation	White, N.C.	White, best age group in nation
All ages	11,647	7,191	3,953	-38.3	-66.1
Under 1	1,913	1,211	617	-36.7	-67.7
1 - 4	436	237	133	-45.6	-69.5
5 -14	333	192	120	-42.3	-64.0
15-24	1,037	387	182	-62.7	-82.4
25-34	1,221	402	201	-67.1	-83.5
35-44	1,281	480	284	-62.5	-77.8
45-54	1,500	641	383	-57.3	-74.5
55-64	1,589	873	499	-45.1	-68.6
65-74	1,355	1,339	796	- 1.2	-41.3
75-84	617	813	498	31.8	-19.3
85-up	365	616	240	68.8	-34.2

Source: C. Horace Hamilton, "Life and Death In North Carolina", Medical Care Needs and Plans for Rural People in North Carolina, Reprint, A Series of Newspaper Articles, July, 1944 and March, 1945, pp. 11-13.

Other Results

Many other indexes which are the direct result of the lack of medical care facilities are available for exploration; however, only a few will be touched upon here.

The important causes of death among Negroes as compared with the white population reflects the lack of facilities and personnel as well as economic status and their cultural behavior patterns. For example, the extremely high cost in loss of life among Negroes from tuberculosis reflects their poor economic and educational status as well as inadequate medical facilities and services. On the other hand, the high loss of life due to syphilis not only reflects these conditions, but more important, they point to over crowding in houses and very inadequate recreation facilities in most of our communities.

Never before has the meaning of loss of time due to illness been brought so vividly to light as during the present emergency

when every man-hour of labor is so important to the life of the nation. Illness may be sufficiently severe as to make work impossible or it may be just enough to impair working efficiency. In either case, the net result is decreased production. It is now a well established fact that socio-economic status and morbidity rates have an inverse relationship - low status and high rates of illness. The Negro therefore, is ill a great deal because he is poor or poor because of sickness, but regardless of which comes first, the simple truth is that he cannot purchase needed medical services under our present system.

The percentage of registrants rejected for military service is so high as to be both amazing and alarming. In 1943, between two-thirds and three-fourths of the Negro and about one-half of the white registrants examined were rejected for military service; North Carolina had the dubious distinction of being in first place among the states for both white and Negro rejections. Many of these physical deficiences would have been prevented and would not now be reoccurring under a system of complete medical care which would insure that: (1) Every person receives instruction in individual and community health problems; (2) Adequate facilities and personnel are available; and (3) An equitable method of paying for needed services exists.

V. Co-ordinating Plans

In a previous section of this report, existing medical care facilities and personnel have been catalogued and analyzed in relation to the structure of population and needs of the people. Also, the direct results of inadequate services were described in some detail. It now becomes necessary to implement those data with the view of pointing the way towards methods of obtaining a more complete system of medical care for all the people.

This, the concluding section is not an attempt to map out a detailed plan for securing more adequate facilities; however, the purpose here is to lay out sound principles of organizational procedure so that it may be possible for the Negro population to receive all required services within the broader framework of plans for the total population. 11/ The Negro population is here the focus, but the base out of which all human endeavor begins and ends is the total population - all the people in North Carolina.

1. Medical care facilities for Negroes are very meager in North Carolina. However, the mere increase in facilities will not completely remedy this situation. The average economic base of Negro families is far too low for a very large part of them to buy the services they need and want. The solution to this complex situation is neither easy nor is it insurmountable. The answer is to be found in the twin approach of increased facilities plus a systematic method of prepayment which will enable Negroes and whites alike to purchase needed and desired services.

2. The people of North Carolina are too poor to afford bilateral arrangements in health education, medical care facilities

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11/ M. O. Bousfield, M. D., "Reaching the Negro Community," American Journal of Public Health, Vol. 24, No. 3, March, 1954, pp. 209-215.

and in methods of paying for their services. At the same time, the state is too poor not to provide for one complete system of medical care. Two systems will mean lower standards and poorer services for both the white and the Negro population.

3. It is generally recognized that local medical schools have an important influence on the number of graduates who practice in the state. Evidence shows conclusively that those states with greater facilities for complete medical training have more adequate personnel available to serve the population. Therefore, if this state is to have more Negro medical personnel, there should be training facilities within the state. This means very simply a complete medical school for Negroes. Perhaps the state cannot afford to support two schools of high standards, but it can support one. It follows logically that facilities for training Negroes should be in the general system constructed to serve the total population. Regardless of the location of the physical plant, it would be desirable for the Negro medical students to be graduated from the University system.

4. Within the next few years, the state with local and federal support will launch a great program of hospital construction and expansion. The need in rural areas is very urgent. A two-system arrangement - one for whites and another for Negroes - is neither financially feasible nor is it desirable. In 1939 a group of persons trained and experienced in hospital administration met with the Surgeon General of the United States and agreed: " . . . that the interests of the colored race would be best served by making provision for them in institutions designed to serve the entire population rather than by the establishment of separate hospitals caring for Negroes only." 12/ The important principle considered here is that total resources are to be mobilized for the welfare of the total population, not overlooking the necessity, however, of taking into account the needs of each segment.

5. A final factor to be considered is the matter of personnel in health education - in this case public health programs. It has been demonstrated many times over by public agencies and private concerns that trained Negro personnel can influence Negroes to a greater degree than white personnel. This is a sound psychological and educational principle and should be heeded. This simply means placing more responsibility for Negro health education in the hands of the Negro leaders.

Rapid expansion of knowledge concerning medical care by the folk of the state has given rise to a demand for total application of modern medical science. The people are speaking with authority. It now becomes the responsibility of leaders to develop the plan and procedure so as to give to the people of North Carolina what they want and need. Their demands for improving living standards must be met.

12/ Journal of the American Medical Association, Vol. 115, No. 17, p. 1461.