THE CITY THAT CARE FORGOT: APARTHEID HEALTH CARE, RACIAL HEALTH DISPARITY, AND BLACK HEALTH ACTIVISM IN NEW ORLEANS, 1718-2018

A Dissertation
submitted to the Faculty of the
Graduate School of Arts and Sciences
of Georgetown University
in partial fulfillment of the requirements for the
degree of
Doctor of Philosophy
in History

By

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Washington, DC
June 16, 2020
THE CITY THAT CARE FORGOT: APARTHEID HEALTH CARE, RACIAL HEALTH DISPARITY, AND BLACK HEALTH ACTIVISM IN NEW ORLEANS, 1718-2018

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ABSTRACT

This work examines the apartheid health care system in New Orleans from the city's founding in 1718 through the present, addressing several research questions. What factors led to the development and perpetuation of the apartheid health care system in New Orleans? What are the connections between apartheid health care and the larger system of racist hierarchy? How has apartheid health care impacted the health of Black residents? How have Black New Orleanians fought against this system and for improved health?

This work main's arguments can be summarized as follows. First, apartheid health care emerged as a key component of the slave-based economy, became institutionalized with the end of Reconstruction and the rise of Jim Crow, and helped support the system of segregation in the Crescent City; sadly, an apartheid health care system still exists today. Second, the medical system served white interests in ways that financially benefitted members of the medical community and both accommodated and supported the prevailing economic system and racist hierarchy from slavery, to Jim Crow, to the post WW-II liberal order of de jure segregation, and into the post-Katrina world of ascendant liberalism. Third, government policies at the local, state, and federal level helped the apartheid health care system grow and sustain. Fourth, within these shifting institutional and power structures, Black New Orleanians fought for access to health care
and improved health, including carving out their own health care system, but always had to confront the limits imposed by the racist hierarchy.

Ultimately, this work posits that the apartheid health care system's survival was not inevitable. Although many factors facilitated its rise and perpetuation, there were crucial turning points when the apartheid health care system could have ended. These moments occurred in the late 1860s and 70s, the late 1960s and 70s, and post-Katrina, when opportunities existed to dismantle, not expand, the apartheid health care system in New Orleans. These opportunities evaporated, but only because individual actors chose to maintain the apartheid health care system.
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INTRODUCTION

Introduction

As I write this introduction, New Orleans is in the midst of an epidemic of COVID19. For the past several weeks, the New Orleans metropolitan area has had the highest COV19-related mortality rate in the country. New Orleans is hardly a stranger to epidemics. Diseases like yellow fever, smallpox, and cholera earned the city the label the "Necropolis," the "city of the dead," in the nineteenth century. In the twentieth century, epidemics like tuberculosis, bubonic plague, influenza, and HIV/AIDS helped maintain the city's higher than average mortality rate. Thus, New Orleans's current status as a disease center aligns closely with the city's past.

While the ongoing COVID19 outbreak represents a continuity of health issues affecting the Crescent City, a possibility exists that through discussion and analysis of this epidemic, Americans can finally address a long-standing issue not just for New Orleans, but for most areas in the United States: racial health disparity. On Tuesday April 7, 2020, Governor John Bel Edwards gave his daily press briefing on Louisiana's ongoing epidemic of COVID19. That day, Governor Edwards highlighted a particularly startling fact that had been uncovered in the disease's preliminary statistics: although Black Americans made up less than 33% of Louisiana's population, they comprised more than 70% of COVID19 fatalities.

For many Americans, this racial disparity, seen in cities like Chicago, Detroit, Milwaukee, and New York City, seemed shocking. Dr. Anthony Fauci, the head of the

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2 Jason Lemon, "70 Percent of Corona Virus Deaths in Louisiana are African Americans," Newsweek, April 7, 2020.
National Institute of Health addressed the topic in his national briefing that same night. Fauci highlighted the disproportionate number of Black American deaths nationwide due to COVID19 and told reporters that disasters like coronavirus could "shine a very bright light on some of the real weaknesses and foibles in our society." Fauci dismissed biological reasons for the higher Black death rate, and instead emphasized "underlying medical conditions — the diabetes, the hypertension, the obesity, the asthma—" as the primary cause of higher admittance rate to intensive care units and mortality rates. Ending his briefing, Fauci spoke of the need to address this problem: "So when all this is over — and as we said, it will end, we will get over coronavirus — but there will still be health disparities which we really do need to address in the African American community."3

These comments on comorbidity matched the high prevalence of chronic health conditions afflicting Black residents in New Orleans: significantly higher rates of diabetes, heart disease, stroke, cancer, infant mortality, maternal mortality, asthma, lead poisoning, and HIV/AIDS than whites. Black New Orleanians in the 2000s and 2010s died at a rate twice that of whites and could expect significantly lower life-expectancy. Individuals born in the late 1990s and early 2000s in the mostly Black and low-income Hoffman Triangle neighborhood had a life expectancy of only 55 years; individuals born in the mostly white and affluent Lakeview area had a life expectancy of nearly 80 years.4

3 Jake Lahut, "Fauci says the coronavirus is 'shining a bright light' on 'unacceptable' health disparities for African Americans," Business Insider, April 7, 2020.
Yet, focusing primarily on pre-existing health conditions can be misleading, particularly without examining the historical, structural roots. Racial health disparities, seen in higher Black rates of disease and mortality and lower rates of life expectancy reflect what scholars call "social determinants of health," what the Centers for Disease Control and Prevention identifies as the "conditions in the places where people live, learn, work, and play" that "affect a wide range of health risks and outcomes." These conditions include income and economic security, access to healthy foods, neighborhood safety, conditions of the built environment, education, and access to health care.

The last topic has received increasing attention in recent years, spurred by national conversations about the Affordable Care Act and Medicare for All. While just one of many components of social determinants of health, inadequate access to health care plays a large role in perpetuating racial health disparities. In the United States today, Black Americans have significantly lower access to health care than whites. The 19% rate of being uninsured for Black Americans is significantly higher than the 12% rate for whites. Over 23% of Blacks have skipped seeing a doctor in the past year due to costs.

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compare to 15% of whites. Over 21% of Blacks have no health care source other than the emergency room when sick, compared to 16% of whites. Finally, over 20% of Blacks have made no health care visits at all in the past year, compared to 17% of whites.

Nationally, this has helped account for racial health disparities, as seen in higher Black rates for many diseases than whites: Children's Asthma—14% v. 6%; diabetes—11% v. 7%; and HIV/AIDs—49.8 per 100,000 compared to 5.9 per 100,000. In turn, Black Americans suffer from higher disease mortality rates: infant mortality—11 per 1,000 v. 4.7 per 1,000; diabetes mortality—38.7 per 100,000 v. 18.8 per 100,000; heart disease mortality—204.2 per 100,000 v. to 167.3 per 100,000; and cancer mortality—178 per 100,000 v. 157.9 per 100,000.7

These interrelated problems, lack of access to health care and racial health disparities, have deep historical roots. As detailed by historian Beatrix Hoffman in *Health Care for Some: Rights and Rationing in the United States Since 1930*, health care inequality has characterized the American health care system for the past century, with correlated health disparities.8

As in many cities, in New Orleans racial inequality in health care dates back hundreds of years, to the city's founding in 1718. In the colonial and antebellum periods, rudimentary and profit-driven treatment from enslavers and "slave hospitals" provided the limited medical care for enslaved African Americans, supplemented by care by lay and spiritual Black healers. Post-emancipation through the twentieth century, Black New Orleanians primarily relied on two hospitals: the Black-administered Flint Goodridge

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Hospital, opened in 1896 and closed in 1985, and Charity Hospital, the underfunded and overcrowded state-administered public hospital. After Flint's closure, even though New Orleans had one of the nation's highest concentrations of physicians at a rate of more than 300 per 100,000 residents and contained 25 hospitals in the metropolitan area, Black residents predominantly used only Charity Hospital. That institution, in a dilapidated structure opened in the 1930s, provided medical care for 75% of Black New Orleanians by the end of the twentieth century. Fewer than 15% of the patients served by Charity Hospital earned over $20,000 dollars annually; half of its in-patient services were designated for the uninsured. Charity provided most of the area's uncompensated in-patient and out-patient services. In addition to the uninsured, Charity provided care for most of the city's Medicaid and Medicare recipients.\(^9\) Despite the eight other acute care hospitals in the city, Charity's emergency room, one of the busiest emergency rooms in the country and the only Level 1 trauma center in 300 miles, served most of the acute-care cases. Additionally, the hospital's clinics—the city desperately lacked clinics and primary care in general for low-income residents—served 350,000 patients annually.\(^10\)

Despite this high usage, the hospital had been in decline for decades. Following the contentious and fiercely resisted battle for hospital desegregation, Charity finally integrated in the late 1960s after hundreds of years of segregation, discrimination, and mistreatment of Blacks, including non-consensual medical experiments. After integration, the hospital became majority Black in its clientele as whites sought services at the city’s and surrounding suburban hospitals. Integration came to Charity, but money

\(^9\) 33% of Charity's patients relied on Medicaid, and 11% used Medicare; only 6% of patients at Charity had private insurance.

fled. The state continually cut the hospital's budget and reallocated federal funding meant to compensate the hospital for services for Medicaid and Medicare patients, resulting in repeated threats of closure and multiple episodes of accreditation loss. The funding cuts led to a decline in the quality of care and years of backlogged repairs made the hospital unsafe. Patients were treated with outdated technology and inadequate supplies. Physicians and interns initiated exoduses, and those who stayed dealt with overcrowding and the closing of beds and services. By 2004, the average wait time for emergency room services at Charity was up to 12 hours. The average waiting period for an appointment at a Charity clinic was six months.\textsuperscript{11} For decades, Louisiana State University—which administered the hospital—had been lobbying unsuccessfully to replace the aging Charity with a modern, university hospital. Without financial support for this plan, Charity Hospital continued to operate as the city's main hospital for low-income and Black residents. For many of these individuals, the emergency room at Charity was their only source of health care.

A remarkably different health care system served the white, middle and upper-class, those with insurance and options. In contrast to the one public hospital that predominantly served Black residents, twenty-four hospitals, mostly private, served the white and middle and upper income population. These institutions, like Touro Infirmary, Tulane University, and Ochsner Foundation Hospital were well-funded, well-equipped, and fully staffed. In lieu of the open wards in Charity Hospital, patients in these institutions had private rooms. Services for uninsured patients comprised an average of 4\% of total services at these hospitals. Most patients at these hospitals—many of which

\textsuperscript{11} Kevin U. Stephens, “Governor’s Health Care Reform: Region 1 Consortium Update.” \textit{Louisiana Regional Health Care Consortium Region One}, March 17, 2005, 4.
had refused to admit Black patients until forced to do so by lawsuits and federal legislation in the 1960s—were white. Few patients used Medicaid or Medicare. In fact, many of these elite hospitals faced federal investigations by the former Department of Health, Education, and Welfare, and they spent years on class action lawsuits that lasted until the late 1980s because of discriminatory practices from illegally turning away Medicare and Medicaid patients, treating Black patients poorly, and racist hiring and employment practices. In contrast to Charity, many of these hospitals were thriving by the early 2000s. Ochsner, which had been established as a "white flight" hospital at mid-century, had become the region's largest hospital conglomerate and the area's largest single employer. Quality of care was generally high, and wait times low. Perhaps more importantly, instead of relying on the emergency at Charity Hospital as their main form of health care, these patients had access to primary care, clinics, and private practices, meaning many could avoid using the hospitals altogether.

The differences between Charity and the other hospitals in the area demonstrated the clear existence of a two-tiered health care system, one for the low-income and Black residents, and a second system for the non-indigent and whites. This system was not new. Apartheid health care had existed for hundreds of years in New Orleans. This work, the first to explore the historical development of one city's apartheid health care system, traces that history.

**Argument**

This work examines the apartheid health care system in New Orleans from the city's founding in 1718 through the present and addresses several research questions. What factors led to the development and perpetuation of the apartheid health care system
in New Orleans? What are the connections between apartheid health care and a larger system of racist hierarchy? How has apartheid health care impacted the health of African American residents? How have African Americans fought against this system and for improved health?

Apartheid health care emerged as a key component of the slave-based economy in New Orleans, and then became institutionalized with the end of Reconstruction and the rise of Jim Crow. This system helped support segregation in the Crescent City, and sadly, an apartheid health care system still exists today. The New Orleans medical system served white interests in ways that financially benefitted members of the medical community, and it both accommodated and supported a racist economic system and hierarchy which survived from slavery, to Jim Crow, to the post WW-II liberal order of de jure segregation, and into the post-Katrina world of ascendant liberalism. Government policies at the local, state, and federal level helped the apartheid health care system grow and sustain. Within these shifting institutional and power structures, Black New Orleanians fought for access to health care and improved health, including carving out their own system, but they always had to confront the limits imposed by the racist hierarchy.

The apartheid health care system produced profit for its participants. In the period of enslavement, "slave hospitals" derived much of their income from enslavers paying for medical treatment for enslaved people. For doctors that conducted medical experiments on enslaved and free Blacks, they garnered accolades for innovating medical advances, amassed prestige, and attracted new clients when they applied their perfected techniques and devices on white patients. For medical schools in which students practiced newly
learned skills on the live bodies and cadavers of enslaved people, these practices helped boost their enrollments. After the abolishment of slavery, the removal of the profit motive—treatment paid for by enslavers—helped lead to the exclusion of Blacks, most indigent, from the health care system. Profit continued to impact the apartheid health care system in the twentieth century as well. This is evident in the decision by private hospitals in the post-integration period to continue to deny Black Medicaid and Medicare patients, while admitting a small number of upper-income Black patients.

The apartheid health care system also benefitted the city's larger economic system. Doctors and hospitals played a key role in sustaining the slave-based economy; later, they would help fuel the emerging trade and tourism-based economies; and finally, health care became its own economy with a proliferation of medical schools, hospitals, clinics, rehabilitation long-term care facilities, nursing homes, and biomedical companies that employed tens of thousands of residents and brought great wealth to the city in the later twentieth and early twenty-first centuries.

Yet, profit and economic impact alone cannot explain the persistence of apartheid health care. The system endured in large part because of its symbiotic relationship with racial hierarchy. Even as whites in power caused racial health disparities by denying access and care, they used pseudo-scientific ideas of Black inferiority to justify their actions and pointed to higher Black rates of disease and mortality as an argument to maintain the very system that caused it. In the propagation of slavery, and later Jim Crow segregation, health care apartheid was always protected. This created and sustained a self-perpetuating loop: the health care system exploited or denied admission to Blacks, arguing they were inferior; then used the resulting higher disease and mortality rates as
proof of their inferiority to justify the exclusion not just in hospitals, but throughout the Jim Crow system.

Government policies and powers facilitated the growth of the apartheid health care system. Beyond state-sanctioned slavery and Jim Crow laws, in the twentieth century federal programs like the Public Works Administration and the Hill-Burton Act, which offered matching federal funds for hospital additions or new construction, helped segregated and whites-only health care institutions grow. Meanwhile well-intentioned and more accessible programs like Medicare and Medicaid financially damaged Black-owned and Black-serving health care institutions. At an even greater level, the decision in the United States to eschew state-controlled health care helped fuel the profit-driven and less regulated health care system in which discrimination perpetuated. At the local level, the municipal government used its powers, particularly zoning, to promote white health care institutions, and restrict Black ones.

Despite these forces aligned in favor of apartheid health care, Black New Orleanians have pushed for nearly three hundred years for equal access to health care and health equality, as part of the larger Black freedom struggle. These efforts have included self-help measures like establishing ward civic improvement leagues; the creation of a Black medical profession, with schools and hospital, and an alternate medical district; and efforts to gain access to and integrate the main, white health care system. While unsuccessful in dismantling the apartheid health care system or eliminating racial health disparities, these efforts had significant impact on quality of life.

The apartheid health care system's survival was not inevitable. Although many factors facilitated its rise and perpetuation, there were moments when the apartheid health care
care system could have ended. In his 1982 work *Making the Second Ghetto*, Arnold Hirsch identified several "crucial turning points," which he defined as "an opportunity for dismantling instead of expanding" residential segregation in Chicago in the postwar period. Similarly, this work identifies several such crucial periods, particularly the late 1860s and 1870s and the late 1960s and 1970s, when opportunities existed to dismantle, not expand, the apartheid health care system in New Orleans. These opportunities evaporated, but only because individual actors chose to maintain the apartheid health care system. It is my hope that by identifying these key historical factors and crucial moments that led to the continuance of apartheid health care, contemporary actors can finally dismantle it.

This work purposely uses the term "apartheid health care" in the title. The term apartheid originated from South Africa's policy of institutionalized racial segregation. Scholars of South African health care have described that system as characterized by deliberately providing care that favored whites and discriminated against non-whites; that offered greater funding for white patients than non-white patients; and served as "instruments of the state in achieving Apartheid goals" of "reproducing the conditions of capitalist accumulation and maintaining white supremacy."13

As demonstrated in this work, those same characteristics apply to health care in New Orleans. The main health care system purposely discriminated against Black residents, provided less funding—and in some periods, no funding—for Black patients,

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and served as instruments of white racist hierarchy in promoting economic goals—from supporting the slave-based economy, to the trade and tourism economy in the twentieth century, and the health care economy itself in the post-WWII period into the present—and maintaining white supremacy. Government policies and funding has supported apartheid healthcare in New Orleans, and in turn, apartheid healthcare has supported and justified the racist white hierarchy. As in South Africa, self-interest—both in terms of ensuring that enough Black workers survived work in economic systems like the plantation economy and later shipping and hospitality, and also did not spread contagious disease to whites—motivated the limited support from white leaders and donations from white residents for Black health care for much of the city's history. As such, the term "apartheid health care" better describes the system in New Orleans than terms like two-tiered health care or health care inequality.

Literature Review

This dissertation builds upon scholarship in urban history, Black history, and the history of medicine. By deign of my focus on one city, New Orleans, this is a work of urban history. Focusing on one city over the course of a long time frame offers several advantages. As historian Guian McKee has noted, traditionally academics have analyzed health care at the federal policy level or as part of the history of medicine, without examining health care and its impact at the local level. Several noteworthy books take the former approach, and offer macro-level examinations of the history of hospitals and medicine over a long time period. Two prominent examples are Charles Rosenberg's The

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Care of Strangers: The Rise of America's Hospital System and Rosemary Stevens's In Sickness and In Wealth: American Hospitals in the Twentieth Century.\textsuperscript{15} Rosenberg analyzes the development of American hospitals primarily from the Civil War through 1920 by detailing how the hospital became the center of American medicine, as well as the advent of modern medicine. Stevens's work explores the period immediately after 1920, and traced the evolution of American hospitals in the twentieth century. Even more ambitious in scope, Paul Starr's The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry examines the rise of the medical profession from the country's founding through the late twentieth century.\textsuperscript{16}

While exemplary scholarship and key works in the field of the history of medicine and health care, these books have several limitations. These scholars mostly eschew discussion of discrimination or the apartheid health care system; in fact, there is currently no one single work that focuses primarily on the history of apartheid health care. Macro-level books explore the factors that shaped the developments of the national American hospital and medical system, but rarely do they examine the local level. In contrast, my study focuses on the local level by concentrating on New Orleans, and it analyzes not only the factors that shaped the hospitals and medicine, but also how the medical system shaped the city and its residents, from where buildings were built to where housing was racially designated. As such, this work adds to the general field of urban history, especially literature on the historical effect of the health care system on American cities.


While these works are few, several scholars have begun addressing the impact of health care on cities, particularly the growth of the health care economy in the postindustrial period. In 2016, the *Journal of Urban History* devoted a special section of their March issue to this topic, and one of the contributors, historian Andrew Simpson, published in *The Medical Metropolis: Health care and Economic Transformation in Pittsburgh and Houston* in 2019. The book examines the impact of the expanding health care economy on those two cities from the late 1940s onward, as both cities promoted health care as a key economic growth sector. Simpson's work offers a model for other historians examining the impact of health care on urban politics and development.17

While Simpson focuses on the post-industrial period, my dissertation centers a longer time frame approach like Starr's *The Social Transformation of American Medicine*. By doing so, this work reveals the patterns, continuities, and changes in the health care system in New Orleans. My work still details the individual actors, decisions, and nuances that are often lost in a larger narrative. As argued by historian Keith Wailoo in his seminal work on sickle cell anemia in Memphis, it is important to view:

...[the] local aspect, the story of disease transformation involved people, institutions, and forces often hidden from the national spotlight...By looking at Memphis, we can also discern the fine grain of human relationships and the ways in which the worlds of science, medicine, urban politics, race relations, and health beliefs conjoin in twentieth century America.18

I similarly explore Black health and health care in New Orleans to reveal more about the ways science, medicine, urban politics, race relations, and health beliefs have conjoined.

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My reasons for choosing New Orleans are multiple. I have lived off and on in New Orleans for nearly a decade. It is a city that I both know well and love. I previously completed my Master's degree at the University of New Orleans, and I have a strong grounding in the city's history as well as experience with many of the archives I used for this project. Thus, New Orleans offered both familiarity, practicality, and the opportunity of a "labor of love" to sustain what can be a long and deeply challenging process.

A rich body of literature exists on New Orleans, although the majority of it is primarily concentrated on the periods of French and Spanish control, and the American antebellum period when New Orleans was a major port of trade and slavery, with fewer works on the twentieth century. I examine those periods, but concentrate primarily on the late nineteenth and twentieth centuries; this approach helps address this gap and adds to the scholarship on this later period, particularly the scholarship on race, as well as the

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scant works on health and health care. Works on health and health care in New Orleans include Todd Savitt’s examination of Straight University's failed attempts at a Black
medical school in late nineteenth century New Orleans; physician John Salvaggio's history of New Orleans's Charity Hospital; Urmi Engineer Willoughby's exploration of the origins of and efforts to eliminate yellow fever in the city, as well as racialized notions of Black immunity to the disease; and journalist Sheri Fink's narrative of the harrowing experiences of patients and physicians trapped in Memorial Hospital during Hurricane Katrina.²¹

One of the dangers of focusing on New Orleans, is the idea of the "exceptionalism" or "uniqueness" of the city." Proponents of this claim attribute this difference to the city's history—particularly the long control by the French, and later the Spanish—and creolized culture. Therefore, they argue, New Orleans is fundamentally different from other American cities. New Orleans is sometimes called the most Europeanized American city; others describe the Crescent City as the Caribbean north. Scholars committed to challenging this notion of exceptionalism have attempted to counter this idea by placing it in the context of the larger Atlantic world to show its connections and similarities to other global cities.²² The 2019 edited volume Remaking New Orleans: Beyond Exceptionalism and Authenticity proffers fourteen separate essays

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by scholars from a variety of disciplines that unpacked the notions of exceptionalism and cultural authenticity ascribed to New Orleans. These limiting ideas began propagating as the city increasingly turned towards promoting itself as a tourist destination in the early twentieth century.23

While this work does not seek as its primary purpose to join the scholarly discourse on authenticity and exceptionalism, I do claim that a case study of health care in New Orleans offers insights into the history of many American cities. In other words, this work uses New Orleans not because of an exceptional history of health care, but because of it also shares similarities with other U.S. cities. Today in New Orleans the health care sector is the second largest employment sector, behind only the hospitality field—more than 21,000 people work for the city's five largest hospitals alone—and hospitals and other health care buildings occupy large swaths of the physical landscape. New Orleans is increasingly becoming dependent on the health care economy. This is perhaps most visible in the recently opened University Medical Center and the Veterans Administration Hospital, both costing more than a billion dollars each, and part of the BioDistrict, an economic development area covering over 1,500 acres in the heart of downtown.

New Orleans is not unique in the focus on the health care economy. Many cities, particularly post-industrial ones, have increasingly turned to the health care sector to boost employment and public dollars, even as scholars warn of the dangers in relying on

23 Thomas Jessen Adams and Matt Sakakeeny, eds., Remaking New Orleans: Beyond Exceptionalism and Authenticity (Durham: Duke University Press, 2019). For more on this creation of a tourism economy, see Souther, New Orleans on Parade and Stanonis, Creating the Big Easy. See, also Thomas, Disaster and Desire in New Orleans for more analysis of contemporary tourism.
the health care field for economic growth and stability, and have detailed the role of the health care sector, particularly university hospitals, in gentrification. But beyond this recent expansion, like New Orleans, cities throughout the United States witnessed significant growths in the health care economy, especially after the passage of the Hill-Burton Act in 1946. Even in earlier periods, hospitals played significant roles in many cities and their economic life. For example, "slave hospitals" existed in Charleston, Mobile, Augusta, and other southern hubs, not just the Crescent City. As in New Orleans, these institutions helped create powerful health care sectors that would drive city growth.

The health disparity that exists today in New Orleans, one which has persisted for hundreds of years, is not unique to the city. The same social determinants of health and their negative impacts on Black health, permeate throughout the U.S. As in New Orleans, African Americans in Atlanta, Chicago, Los Angeles, Milwaukee, Rochester, Trenton, and other cities face significantly higher disease and mortality rates due to poverty and inequality. Black residents in these cities have disproportionately relied upon overcrowded and underfunded public hospitals. Racial health disparities and apartheid health care systems exist in most American cities. Additionally, like many cities, New Orleans has a large population of people of color who live in the urban core. They have experienced the consequences of white flight, urban renewal, and deindustrialization. While this work concentrates on New Orleans, the findings mirror the history and experience of many Black Americans living in urban centers.

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Few works in the field of African American health history have focused on the city level, although some have concentrated on the history of a single Black hospital.\(^{25}\) As in the case of the broader field of the history of medicine, several works have explored Black health care history at a macro level. This includes the two-volume, nearly 1600-page tome *An American Health Dilemma: Race, Medicine, and Health Care in the United States* by physicians W. Michael Byrd and Linda A. Clayton.\(^{26}\) These works look at the history of racial health disparity, racial discrimination in medicine, and racial attitudes tracing back to the period of the Greeks, through European colonization, and into the twentieth century. While ambitious in scope, the volumes are mostly a synthesis of secondary literature. In the words of one reviewer, the works are a "fine reference with limitations," including its reliance on older and unreliable sources.\(^{27}\) In a much slimmer volume designed for undergraduates, David McBride's recent work *Caring for Equality: A History of African American Health and Health care* also offers a synthetic history of Black health inequality and activism.\(^{28}\) Together, McBride and Byrd and Clayton's offer valuable starting points for research.

More concentrated works have explored the development of the Black medical profession, with a series of pioneering works by historians Darlene Clark Hine, David


McBride, Susan L. Smith, and Vanessa Nothington Gamble in the late 1980s and 1990s. Published in 1989, McBride's *Integrating the City of Medicine: Blacks in Philadelphia Health Care, 1910-1965* utilizes an urban history case study lens, detailing the efforts of African Americans to gain employment in hospitals in Philadelphia.\(^{29}\) Published the same year, Hine's *Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890-1950* examines the development of the Black nursing field, primarily focusing on the training institutions; the racism and other obstacles encountered by Black nurses in gaining employment and professional advancement; and the role of nursing professional organizations like the National Association of Colored Graduate Nurses.\(^{30}\)

Smith and Gamble employ Hine's institutional and movement-based approach in their works, both published in 1995. Smith's *Sick and Tired of Being Sick and Tired: Black Women’s Health Activism in America, 1890-1950* examines the health activism of African American women, including public health advocates, nurses, and midwives.\(^{31}\)

Gamble's *Making a Place for Ourselves: The Black Hospital Movement, 1920–1945* examines the Black hospital movement's peak years from 1920-1945, the institutional forces that sustained the movement including the National Medical Association, and the ideological debate over creating separate Black institutions versus pushing for integration. Offering a broad view of the Black hospital movement's most successful period, the book remains the most significant historical work on Black hospitals. In contrast and published a year earlier, Mitchell Rice and Woodrow Jones's


Public Policy and the Black Hospital: From Slavery to Segregation to Integration, while analyzing a longer time frame, takes a more policy-focused approach, examining the impact of federal legislation like the Hill-Burton Act, Medicare, and Medicaid on Black hospitals. Nathaniel Wesley's Black Hospitals in America: History, Contributions and Demise provides short case studies on individual Black hospitals.32

Several recent works have examined the growth of Black physicians in the nineteenth and early twentieth century. Gretchen Long's Doctoring Freedom: The Politics of African American Medical Care in Slavery and Emancipation and Thomas Ward Jr.'s Black Physicians in the Jim Crow South examine Black physicians in the period of enslavement and emancipation, and in the Jim Crow South, respectively, detailing their obstacles and achievements.33

A rich literature details African American health and health care in specific time periods. A number of books with this approach have examined the period of enslavement, with concentrations on Black health and health care on plantations. Notable works include Todd Savitt's path-breaking Medicine and Slavery: The Diseases and Health Care of Blacks in Antebellum Virginia; Herbert Covey's African American Slave Medicine: Herbal and Non-Herbal Treatments and Sharla Fett's Working Cures: Healing, Health, and Power on Southern Slave Plantations, all of which detail the medicinal

efforts of enslaved men and women. Jennifer Morgan's *Laboring Women* and Marie Jenkins Schwartz's *Birthing a Slave* examine the reproduction of enslaved women.\(^\text{34}\) Jim Downs's *Sick from Freedom: African-American Illness and Suffering during the Civil War and Reconstruction* analyze the severe impact of diseases like cholera in period of the Civil War and its immediate aftermath.\(^\text{35}\) An exemplar work on Black health and health care in the early twentieth century is Edward Beardsley's *History of Neglect: Health Care for Blacks and Mill Workers in the Twentieth Century South*, which centers on the conditions that caused health problems like tuberculosis and pellagra for African Americans and white millworkers in Georgia, North Carolina, and South Carolina.\(^\text{36}\) David McBride provides a larger history of Black health issues in the twentieth century in *From TB to AIDS: Epidemics Among Urban Blacks Since 1900*\(^\text{37}\).

Black health care in the Civil Rights era has a limited but growing literature. The fight for improved health and health care is often left out of the Civil Rights narrative and scholarship. Works that do cover the topic, focus primarily on the mid 1960s through the

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1970s, leaving out earlier efforts. Scholarship on this era has often concentrated on the efforts of individual groups. Two of the best works in this vein are geographer Jenna Lloyd's *Health Rights Are Civil Rights: Peace and Justice Activism in Los Angeles, 1963–1978*, which examines health activism in Los Angeles from 1963-1978, and sociologist Alondra Nelson's *Body and Soul: The Black Panther Party and the Fight against Medical Discrimination*, which details the health activism of the Black Panther Party in the late 1960s and 1970s.\(^{38}\) John Dittmer's *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care* explores the health activism of the Medical Committee for Human Rights and Thomas Ward, Jr.'s *Out in the Rural: A Mississippi Health Center and its War on Poverty* chronicled the work of the Tufts-Delta Health Center in Mississippi.\(^{39}\) Other scholars including Karen Kruse Thomas, David Barton Smith, and Mical Raz examine the impact of federal policy like the Hill-Burton Act, Medicare, and the War on Poverty on Black health care in the Civil Rights era.\(^{40}\)

In addition to taking a period-specific approach, scholarship from the past two decades have examined the history and impact of a particular disease. These works

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analyze the conditions that have caused a specific health problem to disproportionately affect African Americans, or become associated with them. The two most influential works in this vein are Keith Wailoo's *Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health* and Samuel Roberts, Jr.'s *Infectious Fear: Politics, Disease, and the Health Effects of Segregation*. Wailoo's groundbreaking book offers a place-based examination of sickle-cell anemia by focusing on Memphis over the course of the twentieth century. Roberts examines tuberculosis in the Jim Crow period, including white efforts to segregate African Americans due to the disease, and the efforts of Black Americans to address the conditions that caused high rates of tuberculosis among urban African Americans. Both books demonstrate the historical misuses of public health initiatives and how racist ideas informed white perceptions of and reactions to higher rates of particular diseases among Blacks, while ignoring the structural causes. In these cases, white authorities and residents instead blamed diseases on the behaviors of African Americans, cultural traits, and racial inferiority. Perhaps more importantly, both works exemplify how historical examination of diseases could provide larger insights into race, health, and inequality in America. Following this tradition, recent works on race and disease include Anthony Ryan Hatch's recent book on metabolic syndrome; Jonathan Metzl's study of Black men and schizophrenia diagnoses; and Christian Warren's work on lead poisoning and his forthcoming book on rickets.

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Some of the early pioneering scholarship on Black health emerged with the works of environmental historians. Robert Bullard, Andrew Hurley, and Ellen Griffith Spears explore the impact of toxins and pollutants on African American towns and neighborhoods, and the Black environmental justice struggle. These works contribute not just to the historical understanding of social determinants of health, but also detailed how Black communities have fought for decades against environmental racism.


Several scholars explore the history of medical experimentation on African Americans, including larger more narrative pieces like Harriet Washington's *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* and more concentrated books that focused on specific episodes, like James Jones's *Bad Blood: The Tuskegee Syphilis Experiment* and Susan Reverby's *Examining Tuskegee: The Infamous Syphilis Study and Its Legacy* which details the infamous Tuskegee Experiment.\(^\text{44}\) More recently, Deirdre Cooper Owen's *Medical Bondage: Race, Gender, and the Origins of American Gynecology* examines the experiments by white physicians on enslaved Black women in the nineteenth century—usually without consent—that drove advances in gynecology as well as pseudo-scientific claims of racial inferiority.\(^\text{45}\) *Medical Bondage* also fits into the field of scholarship—exemplified by Rana Hogarth's *Medicalizing Blackness: Making Racial Difference in the Atlantic World, 1780-1840*—on the role of physicians and medicine in enforcing biological ideas of racial inferiority, which helped doctors claim a mantle of authority in the nineteenth century.\(^\text{46}\)

By concentrating on apartheid health care and racial health disparities over New Orleans's three hundred year history, this dissertation touches upon and adds to these


literatures and approaches. I cover various time periods and a number of diseases. I also
pay attention to institutions; this study examines the development and decline of a Black
medical school and hospital, the creation and fate of a Black medical district, and the
struggles of the Black medical profession. I uncover medical exploitation and
experimentation, the pseudo-scientific claims of physicians, the misuses of public health,
components of the social determinants of health, and the history of racial discrimination
in health care.

My work is purposely titled "Apartheid Health care in New Orleans" rather than
"Black Health care in New Orleans." This title reflects a decision to fuse together two
often separate strands in the history of medicine. Monographs and edited volumes about
the history of medicine, hospitals, and the medical profession predominantly focuses on
white doctors, white patients, white medical students, and white hospitals. Research on
Black health problems, Black health care, Black hospitals, and the Black medical
profession comprise another set of texts. The first field often fails to engage the second
because the health care system has historically employed white medical professionals and
its advances have largely benefitted white patients, while excluding Blacks as
practitioners and patients for much of this country's history. The second field focuses on
the alternate Black medical system, which benefitted from the Black medical schools and
hospitals that started to counter exclusion and the Black healers that helped Blacks who
were denied access to the main health care system. I detail the achievements and
limitations of a Black medical school—Flint; a Black hospital—Flint Goodridge; an
alternate Black medical district—Central City; and Black medical professionals like Dr.
James T. Newman, Dr. Joseph Hardin, and Albert Dent, I do not situate this research as a
piece on "Black health care," rather, I argue that the alternative Black health care system can be best understood in the context of the overall apartheid health care system. Only by detailing the exclusion, exploitation, and discrimination faced by Blacks in health care, can we understand the limitations they faced as both patients and practitioners.

Finally, this work delves into the Black freedom struggle because I am not solely interested in an examination of the damage caused by the apartheid health care and the larger system of white supremacy, I want to contribute to the analysis on how African Americans fought for improved health. I employ a "long civil rights" framework, exploring the fight for access to health care and improved health that started long before the boycotts, sit-ins, and marches of the 1950s and 1960s, by tracing Black health activism from the late eighteenth century through the present. As noted by Nelson in Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination, health activism "must be understood as an important feature of a broader conceptualization of the civil rights movement." Nelson argues that Black Panther Party clinics of the late 1960s and 1970s, while partly a reflection of the spirit of Black nationalism in the period, represented not something new, but rather a continuation of health activism that stretched back to the creation of Black hospitals. While tactics may have changed—first creating separate Black health care institutions, then pushing for integration, then crafting community clinics—followed and modeled their efforts on earlier health activism. I make clear this thread of health activism within the long civil rights framework, stretching back several hundred years through the current present.

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48 Nelson, Body and Soul, 8.
Breakdown of Chapters

Chapter one explores the origins of the apartheid health care system in New Orleans. It details the creation and roles of early hospitals like the Royal Hospital and Charity Hospital, both of which owned enslaved people and provided invaluable medical care to many of the participants in the slave society. It examines the health requirements for enslaved individuals under the Code Noir and Black Codes, and the connection between the growing slave economy in New Orleans and the nascent medical field. The chapter details the role of physicians in promoting scientific racism used to justify the slave system. Finally, the chapter explores health problems of enslaved people, and the limited health care provided by enslavers.

Chapter two details how the institution of slavery permitted the growth of the health care system in the antebellum period, including private hospitals, the state-administered Charity Hospital, the two medical schools, and the practices of individual physicians. Private infirmaries called "slave hospitals" proliferated, buoyed by profits for providing care for enslaved individuals, paid by their enslavers. While not considered a "slave hospital," Charity Hospital strengthened its connections to slavery. The hospital continued to treat the increasing number of arriving enslaved people suffering from illness and bound for the slave market, owned and sold enslaved laborers, and derived income from donations from large enslavers. This chapter also explores the growth of the medical schools and the emergence of New Orleans as the "medical metropolis of the South," a process deeply connected to slavery. Physicians derived prestige and wealth through exploitation and experimentation on enslaved people, and passed down ideas of scientific racism to the next generation of doctors. Finally, this chapter examines the
origins of an alternate source of health care for Black New Orleanians, Black doctors and lay healers.

Chapter three examines one of the "crucial turning points" in the city's health care history. During federal occupation of New Orleans, an opportunity existed to end apartheid health care. While Louisiana abolished slavery in 1864 and enfranchised Black voters, neither state nor federal officials enforced "public rights" by requiring integration of hospitals. Instead, the federal government created the short-lived and underfunded system of Freedmens Hospitals for Black patients, which ended in 1869. From 1868-1877, Charity Hospital desegregated. However, with the end of Reconstruction and return to power of the Redeemers, medical leaders purposely chose to institutionalize apartheid health care, with private hospitals and the University of Louisiana refusing to accept Black patients or students, and Charity Hospital treating Black patients in separate wards. Excluded from health care, and subject to many other aspects of discrimination, the racial health gap widened dramatically. This chapter also examines the early, unsuccessful attempts to create Black medical schools in New Orleans in the 1870s and 1880s, and the final successful creation of the Flint Medical College in 1889, and Flint Goodridge Hospital in 1896.

Chapter four explores the intersection of the segregation of health care and urban space in the early decades of the twentieth century. It examines how New Orleans's push for increasing trade with Latin America and tourism led to civic improvements, public health campaigns, and an expanding health care economy. As boosters promoted New Orleans as a healthy city, with a robust health care system, they also advocated for residential segregation and spatial concentration of Black residents in less-desirable area,
often using arguments of poor Black health as justification for removal. This chapter
details the push by white leaders to evict Black medical institutions like the Providence
Sanitarium, Flint Goodridge Hospital, and Flint Medical College, and the role of
municipal powers and federal funding—through programs like the WPA—in supporting
the efforts to create a white Medical District.

Chapter five explores the efforts of Black New Orleanians to create an alternate
medical district in the Central City neighborhood. It details the attempts to create two
hospitals, the unsuccessful Colored Hospital, and a new Flint Goodridge Hospital, which
became the anchor of the Black medical district. The chapter examines the initial
challenges of the hospital—like fundraising and staffing—and the vision of Flint
Goodridge as not just a hospital but a Health Center focused on three main goals:
expanding hospital care for Blacks throughout the region, tackling the public health
issues facing the Black community, and serving as a training center for Black medical
professionals. Finally, the chapter explores two significant issues for the hospital: the
deliberate effort of the municipal government to prevent the growth of the hospital with
WPA-sponsored "slum clearance" and building of public housing units around the
institution, and the post World War II exodus of Black physicians from the Jim Crow
city.

Chapter six explores the decades-long struggle to desegregate health care in New
Orleans, focusing on the period from the late 1940s through the late 1960s. It examines a
seemingly paradoxical problem with Flint Goodridge Hospital: the desire to expand the
Black institution—thwarted for years by the state's denial of federal Hill-Burton
funding—occurring as Black leaders pushed for access to all hospitals. This chapter
details the new strategies employed by Civil Rights leaders like A.P. Tureaud, who turned to litigation to force desegregation of medical schools, and the impact of federal court decisions and legislation like the Civil Rights Act of 1964, Medicaid, and Medicare, which mandated integration of health care institutions. This chapter also details the concentrated efforts of Charity Hospital and private hospitals to defy integration, and the creation of "white flight" hospitals in the suburbs of New Orleans. As this chapter demonstrates, the late 1960s was another potential "crucial turning point" for the apartheid health care system, and white municipal and health care leaders fought to preserve the apartheid health care system.

Chapter seven explores the post-Civil Rights period when the promise of an integrated health care system evaporated and the apartheid health care system became reentrenched, similar to what occurred in New Orleans a century earlier. This chapter starts with two juxtaposed stories: the simultaneous attempts to expand the white Medical District, including the successful creation of Tulane University's new hospital, and the stymied work to expand Flint Goodridge Hospital, which entered into decline. It explores the creation of the state agency Health Education Authority of Louisiana (H.E.A.L.) and its "urban renewal" efforts to displace Black residents and businesses. This chapter explores also continued Black health activism, which took several forms. First, Black residents of Tulane Gravier organized against the expansion of the Medical District and displacement. Second, Black residents and the NAACP initiated litigation against the formerly all-white hospitals that continued to discriminate, leading to investigations by the federal government, and underminded by the failure of the federal government to enforce integration. Third, Black residents pushed for Health Deparment and federally-
funded Model Cities health clinics in public housing units and Black neighborhoods, and the Black Panther Party created their own People's Clinic in the Desire neighborhood; all the clinics proved short-lived. Finally, the chapter examines the transition of Charity Hospital to a "de facto" Black hospital, and the accompanying decrease in state funding and quality of care.

Chapter eight examines Black health care in New Orleans in the age of crisis, from the late 1970s until Hurricane Katrina. It explores the factors that led to the decline, sale, and closure of Flint Goodridge, primarily the hospital's declining finances due to low levels of reimbursement from Medicare and Medicaid, inability to attract donors or investors, and lack of government funding. This chapter also explores the growing corporatization of health care. While Flint Goodridge became a victim of this process, hospitals like Tulane and Ochsner that served a wealthier, whiter clientele thrived, buoyed by their support from hospital companies and continued aid from H.E.A.L. Finally, this chapter details the further decline of Charity Hospital, principally caused by the state's continued reduction in funding. By the 2000s, Charity provided care for 75% of the city's Black hospital patients, as both quality of care at the hospital and the racial health disparity worsened.

The concluding "Black Health and Health Care After Katrina" chapter explores the transformation of health care in post-Hurricane Katrina New Orleans, including Louisiana State University's controversial decision to keep closed Charity Hospital. Aided by political allies and federal funding, LSU succeeded in their long-desired plan to replace Charity Hospital with a modern University Hospital. However, Black residents continued to suffer. The new University Hospital did not open for ten years after the
closure of Charity Hospital. Similarly, the predominantly Black New Orleans East neighborhood waited ten years for the reopening of a hospital in that area. Both of these waits disproportionately impacted Black residents, who made up the vast majority of patients at the two hospitals, and many African Americans had virtually no access to health care. Even when the University Hospital opened in 2015, its abandonment of its mission to provide care for indigent residents in favor of becoming a "destination hospital" for individuals seeking cutting edge medical practices resulted in the exclusion of many former patients. Additionally, the building of the University Hospital as part of New Orleans's expansive BioDistrict, intended to foster the growth of the city's biomedical sector, led to further displacement of Black residents through eminent domain. Although the expansion of Medicaid funding and primary care clinics proved positive for low-income residents, racial health disparity and two-tiered health care remained, most visible in the disproportionate number of Black deaths during the city's Covid19 epidemic.

This disparity in mortality from corona virus will hopefully serve as the impetus for an examination not just of racial health disparities, but of the much larger and historically longer impact of structural racism. Apartheid health care is just one part of the larger issue of negative social determinants of health that have plagued Black New Orleanians since the city's founding. But understanding its historical roots and evolution will help in understanding the continued problem of racial health disparity. I hope this work contributes to that understanding, and the push for racial health equity.
CHAPTER 1: HEALTH AND HEALTH CARE IN THE ERA OF SLAVERY 1718-1843

Introduction

In 1841, slavers kidnapped Solomon Northup, born in freedom in New York in 1807 or 1808. Kidnapped in Washington, D.C., Northup was spirited away to Richmond by enslaver James H. Burch. In Richmond, Northup met Robert, another free Black man from Cincinnatti. The slavers placed both men on board the brig Orleans, bound for New Orleans, the South's largest slave market. On board the ship, the slavers chained Northup, Robert, and others in the hold each night, even during three days of violent storms. All suffered from terrible conditions, exacerbated by three days of storms. All in the hold suffered from sea sickness during the storm, and the effuvia from the ill made the hold "loathsome and disgusting," Northup wrote in his autobiography Twelve Years a Slave. Sick and fearful of enslavement, Northup wished at that moment for the release of death. "It would have been a happy thing for most of us," Northup wrote, "had the compassionate sea snatched us that day from the clutches of remorseless men."\(^{49}\)

Northup survived that event, but his torment only intensified. Several days later, Northup, Robert, and a third man planned to seize control of the ship. However, Robert became ill. The sailors announced Robert had smallpox, a highly contagious and deadly affliction of the period. Robert died, and Northup and the others on board "were all panic-stricken." When the ship arrived in New Orleans, many of those on board too became ill. A physician came to inspect them, and Northup related the death of Robert and his belief that all on the ship now suffered from smallpox. The physician sent the afflicted to

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\(^{49}\) Solomon Northup, *Twelve Years a Slave* (1853), 75.
Charity Hospital, designated by municipal law as the hospital for those suffering from contagious disease. Northup detailed in *Twelve Years a Slave* that he was "entirely blind" for three days. Northup also described his feeling about the potential of dying in the hospital: "I thought I could have been resigned to yield up my life in the bosom of my family, but to expire in the midst of strangers, under such circumstances, was a bitter reflection." After sixteen days at the hospital, enslavers sent Northup and the other survivors to the slave market for sale. Subject to a physical examination to determine his health, and his corresponding worth, Northup noted that he was "bearing upon my face the effects of the malady"—meaning he had scars or pockmarks on his face, telltale signs of smallpox. Northup speculated that his bout of smallpox may have lowered his price from an original $1,500 to a final of $1,000 dollars.\(^5^0\)

Northup labored on a series of plantations in Louisiana, forced to construct buildings, clear land, and pick cotton. Northup's health deteriorated due to overwork, beatings, malnutrition, and poor housing conditions. In 1843, Northup became severely ill, suffering from chills, high fever, weakness, and dizziness. Nevertheless, as he noted, the overseer "compelled" him to "keep my row." As he became sicker, and less productive, the overseer continually lashed him with the whip. After months of illness, Northup could not even leave his cabin, but enslaver Edwin Epps provided no care until he believed Northup close to death. As noted by Northup, Epps's motivation was potential profit loss; Epps, "unwilling to bear the loss, which the death of an animal worth a thousand dollars would bring to him," finally "concluded to incur the expenses" of sending for a doctor. Dr. Hines diagnosed the cause of his maladies as the "effect of the

\(^5^0\) Northup, *Twelve Years a Slave*, 85.
climate." Hines ordered Northup to eat no meat, and to "partake of no more food than was absolutely necessary to sustain life." Despite this dubious treatment, Northup slowly recovered over several weeks, owing more to rest than to Hines's prescribed treatment. Epps soon ordered Northup back into the fields, although Northup felt, it was "long before I was in proper condition to labor." Northup, unlike many in his position, survived. 51

Solomon Northup's experiences have become famous in recent years, especially after the Oscar-winning film Twelve Years a Slave came out in 2015. His memoir provide first-hand accounts that demonstrate the precarious condition of African Americans in the antebellum United States, even those born into freedom, and the brutality of the slave system.

Northup's experiences also illustrate the health problems experienced by enslaved individuals, and their interaction with doctors. Like many, Northup became severely ill during his forced journey to the slave pens. Upon arrival, officials quarantined Northup and others suffering from smallpox to prevent an outbreak, a constant concern in the period. Paid by slave traders, physicians treated Northup to prepare him for sale at the slave market. The examination of Northup and others, often done by physicians, showed the further role of medical professionals in converting the physical body of the enslaved individual into a commodity, into a negotiable sale price. His subsequent illness on the plantation demonstrated the physical toll of slavery on the health of enslaved people, planters' reluctance to call for costly physicians, the financial motivations of medical care, and the limited knowledge of doctors.

51 Northup, Twelve Years a Slave, 177-178.
Northup was witness to the early stage of the apartheid health care system in New Orleans, explored in this chapter. It details the creation and roles of the Royal Hospital and Charity Hospital, both of which owned enslaved people and provided invaluable medical care to many of the participants in the slave society. It examines the health requirements for enslaved individuals under the Code Noir and Black Codes, and the connection between the growing slave economy in New Orleans and the nascent medical field. The chapter details the role of physicians in promoting scientific racism used to justify the slave system. Finally, the chapter explores health problems of enslaved people, and the limited health care provided by enslavers.

**Origins of Apartheid Health Care**

In the eighteenth and early nineteenth century, members of a family primarily cared for the sick. Only about 4,000 physicians practiced nationwide by the American Revolution, with a mere 200 possessing medical degrees. The first medical school, what would become the University of Pennsylvania, started in 1765, and the first medical school in the south—in Baltimore—began in 1807. Most physicians received training as apprentices rather than formal education, and few states had medical societies or licensing boards. The number of large hospitals nationwide was relatively few. Most Americans distrusted hospitals, perhaps rightfully so with their high mortality rates due to limited scientific and medical knowledge, and medical treatments like bloodletting that caused more harm than good. As a result, many felt that treatment at home was safer. The state's involvement in health care was limited. Some cities had charity hospitals, and most had state-funded facilities for those afflicted by mental disorders. Most Americans

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viewed hospitals as places for the destitute, those without a family to take care of them, and attached a stigma to those who used hospitals.\textsuperscript{53}

Early New Orleans reflected these colonial health care trends. No sustainable medical society existed, and the city's first medical school did not open until 1834. The small number of physicians received training in Europe or through apprenticeships. The French Company of the Indies created a military (or royal) hospital in 1720, administered by Ursuline nuns until 1770. Initially only soldiers and employees of the Company of the Indies could use the space; however, in 1724, the local council voted to allow the hospital to take care of paying civilians.\textsuperscript{54} The indigent could procure a letter signed by the Procurator General that they had no means to pay and could receive free care.\textsuperscript{55} However, in 1731, with the collapse of the Company of the Indies, the French crown assumed control of Louisiana. The Crown cut back on funding for the hospital, and pressured the institution to primarily provide for royal administrators and soldiers, not civilians. The few private physicians offered care for wealthier colonists, but most people primarily relied upon family and friends. The indigent and sailors far from home had no such support system.\textsuperscript{56}

This changed with the opening of Charity Hospital. In January 1736, French shipbuilder Jean Louis died. In his will, Louis bequeathed the money made from the sale

\textsuperscript{53} Starr, \textit{The Social Transformation of American Medicine}, 72.


\textsuperscript{56} Stange, \textit{Vital Negotiations}, 175.
of his property"to serve in perpetuity to the founding of a hospital for the sick of the City of New Orleans." The sale netted 10,000 livres used to create the twelve-bed Hospital of St. John, also known as L'Hospital des Pauvres de la Charite, opened on May 10, 1736, six weeks after Bellevue Hospital in New York City, the nation's longest continually operating hospital. Like the Military Hospital, the Ursuline nuns administered Charity Hospital.\(^57\)

Due to fears of spreading contagion, the Hospital was situated in several locations on the periphery of the expanding city. Originally in a former residence on Chartres and Bienville streets, it then moved in 1743 to Rampart Street. The hospital suffered from overcrowding and underfunding, with no support from the French and little from the colony, instead relying on donations from wealthy patrons. By 1763, the hospital board of administrators comprised wealthy business leaders, as well as clergy and government officials.\(^58\) That year, the Spanish gained control of Louisiana and pledged to continue to provide support for Charity Hospital.\(^59\) In 1779, a hurricane destroyed the building. Don Andres de Almonaster y Roxas, a wealthy land owner, notary public, and alcalde (city councilman) donated 114,000 pesos for the construction of a new brick hospital, completed in 1786, on the previous site. Almonaster also bequeathed an annual gift of $1500 to maintain the institution, now known as the New Charity Hospital of St. Charles.


\(^{58}\) Salvaggio, \textit{New Orleans' Charity Hospital}, 14.

\(^{59}\) Orders by Governor Antonio de Ulloa, March 20, 1766. Rosemonde E. & Emile Kuntz Collection, Louisiana Research Collection, Tulane University (Hereafter referred to as LRCTU).

"Documents certifying that Don Santiago Monlon provided bread to the Royal Hospital for the soldiers and employees of the King," John Minor Wisdom Collection, LRCTU.
The hospital contained 24 beds for a population of 9,756 and, while primarily focused on care for the indigent, allowed paying patients as well.\textsuperscript{60}

Both hospitals only treated whites; no historical records from the French or Spanish colonial periods detail the treatment of the growing number of enslaved Africans or free people of color in New Orleans. This exclusion of Blacks established the apartheid health care system, as Louisiana slowly transitioned from a "society with slaves," a structure where slavery existed but was not the main driver of the economy or social status, to a "slave society," in which slavery acted as the key component economic, political, and social systems.\textsuperscript{61} In the 1720s and 1730s, the Company of the Indies transported more than six thousand enslaved Africans to Louisiana, with many forced to work on indigo and tobacco farms and plantations. Others labored in New Orleans as enslaved cooks and domestics, in skilled trade positions, or on the city's roads, canals, and levees, helping not just to generate wealth for whites but also the infrastructure that would sustain the city's growth.

As Louisiana transitioned to a slave society, white leaders used health care to reinforce the position of Blacks. Early slave codes mandated access to medical care for enslaved people. In 1724, France instituted the Code Noir in Louisiana, which required enslaved people "be properly fed, clothed, and provided for by their masters" (XX); and

\begin{quote}
Slaves who are disabled from working, either by old age, disease, or otherwise, be the disease incurable or not, shall be fed and provided for by their masters; and in case they should have been abandoned by said masters, said slaves shall be adjudged to the nearest hospital, to which said masters shall be obliged to pay eight cents a day for the food and maintenance of each one of these slaves; and
\end{quote}

\textsuperscript{60} A.E. Fossier, "The Charity Hospital of New Orleans," \textit{New Orleans Medical and Surgical Journal} 39 (1923): 728-730.

for the payment of this sum, said hospital shall have a lien on the plantations of the master (XXI).^{62}

Although historians have recently challenged earlier arguments that the Code Noir led to better treatment of enslaved people in Louisiana than in other colonies, in what would become the United States, and the provisions of the statute seem to have been rarely enforced, enslavers did provide some medical care for enslaved people. When enslavers paid for treatment from physicians for enslaved people, they were motivated by a desire to not lose "valuable" enslaved people and to return ailing individuals to profit-producing labor. Some enslavers may have brought enslaved people to hospitals; a dearth of documents from the hospitals and the small number of physicians in the French and Spanish colonial period limits this discussion, but records from the later American period document the treatment of enslaved people by private physicians and "slave hospitals" in New Orleans. This will be addressed in the following section. However, the scant amount of documents do not detail the quality of treatment of enslaved people. Similarly, no records from the period document hospitals treating the growing number of free people of color.

Hospitals that recognized the color line, such as the Military Hospital and Charity Hospital, contributed to both apartheid health care and the sustaining of the slave system. The Military Hospital provided care for company and colonial administrative officials, and Charity treated sailors involved in the transport of enslaved Africans and agricultural products grown, harvested, and refined by enslaved laborers. These services proved vital

to the slave-based system for a city nearly abandoned in the 1720s due to the high death rate. Additionally, these hospitals engaged directly in the slave system through the owning and utilization of enslaved Africans. As part of the contract with the Ursuline nuns to run the Military Hospital, the Company of the Indies—the corporation granted control over Louisiana by France from 1717-1731—gave the religious order eight enslaved people. At the hospital, which the sisters operated with the aid of a physician and three physician's assistants, the nuns used four of these enslaved individuals as laborers. This use of enslaved labor may have made it the first hospital in what later became the United States to do so. 

Charity Hospital also owned and used enslaved individuals throughout its history, starting with the Ursuline nuns in the 1730s. In 1737, Francois Tioucou, a free Black man who had previously earned his emancipation in exchange for his defense of the Louisiana colony during the 1729 Natchez Revolt, entered into a contract with the hospital. Tiocou agreed to work for the hospital for a period of seven years for no pay, and at the end of the term the administrators granted freedom to his wife Marie Aram, an enslaved woman, who would also work for the hospital for the period. The administrators freed Aram in March of 1744 "in reward for the good services she has given to said hospital;" Aram and Tiocou stayed on at the hospital, presumably as paid employees. The Hospital continued to own and use enslaved people. A 1793 hospital document included an enslaved man named Domingo, who is identified as phlebotomist—an individual trained

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63 Salvaggio, New Orleans’ Charity Hospital, 6-7. Cruzat, “The Ursulines of Louisiana.”
64 "Document freeing Marie Arain," March 10, 1744, Master Calendar Collection, LSMHC. For more on free Blacks entering into contracts of servitude to free family members see Spear, Race, Sex, and Social Order in Early New Orleans.
to collect blood—and a 1794 inventory listed three enslaved men who labored as carpenters—Pedro aged 55, Jospeh aged 35, and Phillip aged 60—as well as four children—Andres, 14; Maria, 11; Luis, 3; and Francisco, 2.65

**Americanization**

In 1803, Napoleon sold Louisiana to the United States to help pay for his continued military aims, including his hope to put down the resurrection of enslaved people in Haiti. By the mid to late eighteenth century, an apartheid health care system had already been established in New Orleans and was tied to slavery. Under the American period, apartheid health care would expand and become more entrenched, more profitable, and more closely linked to the growing slave-based economy. Demand for enslaved people in Louisiana intensified with the transition to large-scale sugarcane production in the late 1790s and early 1800s. The end of the international slave trade in 1808 witnessed a more significant role for New Orleans as a slave market, as traders resold enslaved individuals brought from the Upper South for sale to plantation owners in the Mississippi Valley region. At its peak, New Orleans contained 52 slave markets. It is unknown how many enslaved people came through the port, but historian Gwendolyn Hall identified 100,000 individuals forced to labor in Louisiana from 1699-1820 alone, and enslavers purchased many tens of thousands of others from New Orleans, for enslavement elsewhere in the United States.66

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65 "The Constitution for the New Hospital of Charity," 1793, Medical Documents Collection, LRCTU. "Action to Take Possession of the Administration of the Charity Hospital of Saint Charles," 1794, Medical Documents Collection, LRCTU.
Simultaneously, and intricately connected to New Orleans's increasing role as a slave market, the city's medical establishment expanded. The emerging health care needs of the city were evident in the creation of two medical schools, the growth of Charity Hospital, and the flourishing of private physicians and hospitals. The growth of the medical establishment proved fundamental to the city's rise in population and significance as a slave port. New Orleans had one of highest mortality rates of any American city in the first half of the nineteenth century. The mortality rate ranged between a low of 36 deaths per 1,000 in the end of 1820s to a peak of 1 in 15 in 1853. Epidemics of smallpox, malaria, and particularly yellow fever accounted for the high death rate. Yellow fever was actually a direct byproduct of the slave-based system. Slave ships introduced the virus and the main vector, *Aedes aegypt* mosquitoes, from Africa to Louisiana. The transformation of the landscape with wide-scale sugarcane cultivation aided its spread, with new canals, cisterns, and other open bodies of water serving as breeding grounds for mosquitoes, which fed on sucrose from the sugarcane for nutrition. Starting in 1796, and occurring nearly biannually after 1817, New Orleans suffered epidemics of yellow fever that killed more than 100,000 people throughout the nineteenth century. While physicians lacked the knowledge to eliminate these scourges until the late nineteenth and early twentieth centuries, the medical establishment provided a necessary service by providing treatment to the afflicted which helped sustain the city's growth.\(^67\)

**Medicine and Slavery: The Ideologues**

When the city was founded in 1718, leaders at first turned to European convicts and laborers to help clear the land and build New Orleans: the buildings, streets, and

\(^{67}\) For more on yellow fever in New Orleans, see Willoughby, *Yellow Fever, Race, and Ecology in Nineteenth Century New Orleans*. 
protective levees. After many of this initial group died from overwork and disease, the city's leaders began importing enslaved Africans, who they believed had a greater resistance, or even immunity, to disease like yellow fever, malaria, and smallpox. Many physicians in New Orleans pushed this view, repeatedly writing about the issue in medical journals like the *New Orleans Medical News and Hospital Gazette*. Physicians also argued that Africans had a naturally stronger countenance to field labor. Writing in the *Medical News and Gazette* in July 1859, Dr. Anthony Peniston, Professor at the New Orleans School of Medicine, stated there was "no doubt" that Africans were of a "different species of the *genus homo,*" an "intermediate between the Caucasian race and the anthropoid apes." He noted their bones were harder and more dense and their "resisting power" was much greater, which was offset by smaller brains. He continued that their development of "animal and physical properties" occurred "at the expense of the intellectual," in his view. According to Peniston, these properties made them ideal as enslaved plantation laborers.⁶８ By the late eighteenth and early nineteenth century, this belief in Black resistance to disease, need for less sleep, and predisposition for physical labor had become a widely-accepted and institutionalized aspect of the dogma of racialized difference in the white Atlantic World.⁶９

One of the most significant advocates of these pseudoscientific beliefs about races was New Orleans's Samuel D. Cartwright. A popular physician invited to give addresses to various medical groups and schools throughout the region, Southerners used his 1851 report "How to Save the Republic" as scientific proof of the physiological inferiority of

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⁶８ Anthony Peniston, "Memoir on the Races of Mankind," *New Orleans Medical News and Hospital Gazette* 5, no. 2 (July 1859).
⁶９ Hogarth, *Medicalizing Blackness*. 
African Americans and the need for slavery. Cartwright argued that planters must take care of infantile enslaved people, who suffered from drapetomania, a mental illness that caused them to flee if a slave owner was either too cruel or attempted to oppose the Deity's will, by trying to make the negro anything else than "the submissive knee-bender," (which the Almighty declared he should be,) by trying to raise him to a level with himself, or by putting himself on an equality with the negro.

Cartwright infused his ‘scientific’ argument with the supposed biblical role of enslaved individuals, the "position of submission." Many proponents of slavery used Christian beliefs to support the institution of slavery, and the Christian church was a large-scale enslaver in many parts of the United States.70

Cartwright also claimed that African Americans suffered from Dysaesthesia Aethiopica, an affliction brought about by their inherent "rascality" or laziness, particularly in free Blacks—he labeled it the "natural offspring of negro liberty." Cartwright argued that African Americans were naturally lazy and possessed "so great a hebetude of the intellectual facilities, as to be like a person half asleep." Based on his pseudo-scientific studies, Cartwright found evidence that African Americans afflicted by Dysaesthesia Aethiopica unintentionally committed acts of "mischief" like the destruction of "everything they handle" due to their "stupidness of mind and insensibility of the nerves induced by the disease." He also stipulated that African Americans naturally suffered from health problems like skin lesions that they would not take care of when free

due to their inherent laziness. Again, Cartwright's solution was enslavement based on the need of "some white person to direct and to take care of them."\footnote{Samuel D. Cartwright, "How to Save the Republic, and the Position of the South in the Union," \textit{DeBow's Journal} 11, no. 2 (1851): 184-197.}

The claims of Cartwright and others helped legitimate the notion of benevolent slavery. Due to their biological differences, including disposition to the diseases he studied and their low intelligence, African Americans needed the care of enslavers. In fact, many argued that enslaved African Americans were better treated than poor white laborers in the North. These claims mixed with the biblical backing of the "curse of Ham," God's punishment upon Canaan in the Book of Genesis. Christian proponents of slavery argued that Africans were the descendants of Canaan, and differentiated by their black skin, which marked them for slavery.\footnote{See Stephen R. Haynes, \textit{Noah's Curse: The Biblical Justification of American Slavery} (New York: Oxford University Press, 2002).} Cartwright cited this belief in his work as biblical justification for his notions of scientific racism, particularly his argument that Africans and African Americans were naturally disposed to toil in the fields. Other doctors in New Orleans made similar claims. Charity Hospital's Dr. Warren Brickell wrote in 1856 in the \textit{New Orleans Medical News and Hospital Gazette} that Africans were not only more physically inclined to work in the fields, but they also did so "not from compulsion, from choice" even when they suffered from illness, which helped account for their high mortality rate, as they deceived slave owners about health problems—because they wanted to continue field work—until too late.\footnote{Warren D. Brickell, "Epidemic Typhoid Pneumonia Among Negroes," \textit{New Orleans Medical News and Hospital Gazette} 3, no. 1 (February 1856).}

Pseudoscientific arguments helped drive the importation of enslaved Africans to New Orleans to labor on plantations in Louisiana and throughout the Deep South, with
consequences that lasted beyond the period of slavery. Whites would use scientific racism to continue to justify white supremacy and discrimination of Blacks. Scientific racism also contributed to the origins of what physician and historian Rodney G. Hood calls the "slave health deficit," the health inequality between whites and African Americans that persists to this day.\textsuperscript{74}

**The Health of and Health Care for Enslaved People**

Enslaved individuals often arrived in New Orleans from Africa, the Caribbean, and other parts of the United States suffering from severe health problems, if they survived at all. Historians estimate that as many as half of Africans ensared in Atlantic slaving died before leaving the continent, during capture, the forced march to slave holding areas, or waiting in pens and fortresses.\textsuperscript{75} The Middle Passage across the Atlantic Ocean also caused many deaths. Scholars with Emory University's digital Slave Voyages database found that 12.2% of Africans died on board transoceanic ships in the eighteenth century.\textsuperscript{76} Others have concluded that on average between 15-20% of captives died during the Middle Passage from the fifteenth through the nineteenth century.\textsuperscript{77} An additional 4.3% died in the period between when they first arrived where and before they


\textsuperscript{77} Byrd and Clayton, "An American Health Dilemma."
were sold. Even after the end of the trans-Atlantic slave trade in 1808, a period when New Orleans became the largest slave market in the United States, many enslaved individuals suffered through difficult journeys reaching the city. Enslaved peoples were brought by boat or railcars from the North, while others were forced to march overland.

Traders brought the exhausted, underfed, and ill—often suffering from severe problems like scurvy and bacterial infections like yaws—to the slave markets. Upon arrival in New Orleans, captives first encountered the slave system's medical establishment. Officials feared the importation of disease with the arrival of newly enslaved Africans. As a result, they implemented laws to prevent the spread of contagion. In July 1724, the French government ordered health inspections for all enslaved people before they were allowed to disembark from ships. Ordinances under American rule required traders to keep these spaces clean and well-ventilated to prevent the spread of diseases like smallpox and cholera, a significant concern for white city leaders. Traders also had to report diseases to the city council, and send the ill to Charity Hospital.

Slave-traders like J. A. Beard, the largest in the city, brought sick slaves to Charity and later to Touro Infirmary (founded in 1852). Bernard Kendig, another significant slave trader, purposely bought sick enslaved individuals, for low prices, and then brought them to Touro in hopes that physicians could return them to full health. Then, he could sell them for full value. As a result of his schemes, buyers repeatedly sued

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79 Kaplan-Levenson, "Sighting the Site."
80 Salvaggio, New Orleans's Charity Hospital, 7.
81 A Digest of the Ordinances and Resolutions of the General Council of the City of New Orleans (New Orleans, 1845), 28, Records of the City Councils, City Archives New Orleans Public Library (Hereafter referred to as CANOPL).
Kendig for selling them enslaved individuals that were ill or had some kind of hidden medical affliction.\(^{82}\)

In slave markets, traders employed physicians as part of their effort to boost their profits, with values determined by the concept of "soundness." As argued by historians Sharla Fett and Herbert Covey, enslavers looked for "soundness," the health of the enslaved individual as related to their ability to do work, to measure their value.\(^{83}\)

Enslaved individuals that appeared the soundest or healthiest—seeming to have the greatest capacity to labor not just in the present, but in the future—fetched the highest prices. To boost value, and thus their profits, slavers attempted to improve the superficial appearance of enslaved individuals for sale—allowing them to wash, dying hair, trimming beards, giving them more food, and applying oil to make their skin shine. In addition to these measures, slave traders sought to provide care for the sick to improve soundness and boost profits. Traders usually placed those suffering from illness in separate rooms, often to prevent contagion. Many enslaved people arrived sick due to conditions on slave ships or harsh journeys. The slave pens were unhygienic and poorly constructed, with led to further illness. The March 1854 edition of the *News and Hospital Gazette* noted that many enslaved people kept in pens were suffering from pneumonia, bronchitis, catarrh, diarrhea, dysentery, measles, cholera, and whooping cough.\(^{84}\)

Historian Walter Johnson described the care taken before sale as "speculations" on the traders' part, "tactical commitments to slaves' bodies that were underwritten by the hope


\(^{84}\) "Health," *New Orleans Medical News and Hospital Gazette* 1, no. 1 (March 1854): 20.
of their sale." Potential profit motivated care; those deemed less valuable, traders sold quickly rather than provide care as the investment of paying for a physician was not worth the potential return.\footnote{Johnson, \textit{Soul by Soul}, 120, 210.}

While sellers attempted to present sound enslaved individuals to maximize their profit, buyers subjected enslaved individuals to intense physical examination before purchase to minimize their risk. Buyers often required enslaved individuals to strip to inspect their bodies for signs of maladies, and asked them questions about their health histories and current physical conditions. Medical conditions or previous illnesses discovered by buyers or disclosed by the enslaved individual themselves could lower the price or prevent the sale altogether. Physicians wrote pamphlets for buyers on what they should look for on their bodies. Some buyers purchased enslaved individuals "on trial," for periods ranging from a few hours to several months, during which owner could view their ability to work and take them to a physician for an examination. However, this also presented an opportunity for enslaved individuals to fake some affliction to prevent their sale to an undesirable owner.\footnote{Johnson, \textit{Soul by Soul}, 142, 181.}

The redhibition laws, part of the Louisiana Civil Code, helped protect buyers from buying slaves with health problems. Slave traders were required to disclose physical ailments and illnesses, if known, prior to the sale. An 1855 advertisement for the auction organized by the firm of J.A. Beard & Company of 178 enslaved people from the Waverly and Meredith Plantations identified Sarah Moore as having "tonsils occasionally inflamed"; Jack Turner, "slightly affected with gleet"; Henry Cozey, "subject to piles"; Cely, Jacob Turner, Jinks, Kitty, Militia, and Lizzy as "sickly"; Barbara Ann, "crooked
knee"; Modesty, "injured slightly in the head"; John, "asthmatic,"; Harry, "afflicted with palpitation of the heart"; Ezekiel, "slightly rheumatic"; and John Moore, "back injured."
The assortment of injuries detailed the physical toll of labor on cotton and sugar plantations, seen in injuries like the damaged back and crooked knee, as well afflictions like rickets and respiratory problems—detailed more in the following section—caused by factors like malnutrition and poor housing conditions.\textsuperscript{87}

Owners and traders risked lowered sale prices for disclosing problems as described above, but also could face potential lawsuits for failure to detail the information. If a slave trader brought an enslaved individual to Touro Infirmary, the hospital could issue a certificate of health that guaranteed their medical soundness. Buyers could return an enslaved individual to a trader within a year if they discovered the enslaved individual had an unknown severe "vice" like epilepsy or leprosy. However, the code also placed limitations on the returns and "warranty suits" against traders, and taking a trader to court was often a long and costly process, emboldening traders to sell unhealthy enslaved Africans. Physicians often testified in these suits, on behalf of both sides, with the doctors employed by the traders serving as key witnesses for the defense, and physicians also testifying for the plaintiff to discuss a "vice" discovered after sale.\textsuperscript{88}

In addition to physical health problems, buyers looked for "vice of character" as well. Medical journals detailed the biological predisposition of Africans towards "vice of character," like Samuel Cartwright's alleged "drapetomania," the psychological compulsion to run away. Buyers looked to avoid enslaved individuals with these "vices

\textsuperscript{87} "178 Sugar and Cotton Plantation Slaves!", Pamphlet from J.A. Beard & May, New Orleans, 1855, Antebellum Period Collections, LSMHC.
\textsuperscript{88} Johnson, \textit{Soul by Soul}, 131
of character," looking for physical signs, such as whipping marks that indicated punishment for problems like running away.  

Physicians themselves purchased enslaved individuals. Some bought enslaved people suffering from an illness for relatively cheap, in the hope of curing them and then selling them again for a large profit. Other physicians purchased enslaved individuals to conduct medical experiments. In Louisiana in the 1850s, a doctor bought a man named John Brown to conduct sunstroke experiments on him, and later developed a pill which he sold for large profits based on this work. As will be detailed in a subsequent section, medical experimentation on enslaved people became a common practice, with many such incidents occurring in the hospitals of New Orleans.

The roles of hospitals and physicians in this stage of the slave trade—from arrival through sale—demonstrated the deep ties and mutually beneficial relationship between the medical and slavery systems. Charity Hospital protected white residents from the spread of contagious disease from newly arrived enslaved people. Touro Hospital and private physicians treated enslaved people to boost the sale price for slave traders, and it supported the redhibition policies that helped sustain slave sales. Through these actions, the medical establishment not only contributed to the slave economy, but directly to the commodification of enslaved people as their treatments helped turn their bodies into sale prices and wealth. In turn, the medical establishment benefitted financially from this commodification, receiving payment for these services.

89 Johnson, Soul by Soul, 146.
90 Johnson, Soul by Soul, 103.
91 Johnson, Soul by Soul, 102.
This relationship continued after the sale of enslaved people, as hospital and physicians provided medical care for enslaved laborers on plantations. Enslaved individuals on plantations suffered from severe health problems and a high mortality rate. As many as 25% perished during the "acclimation period," the first eighteen month stretch as their bodies adjusted to new locations, climates, and diseases. The Black infant and childhood mortality rate was double the rate for whites. More than half of all Black children were born severely underweight, due to the poor treatment and lack of nutrition for pregnant enslaved women; many women miscarried or gave birth to stillborn babies. On average, Black mothers could only nurse their babies for three to four months, compared to eight months for white babies. The early weaning, and same horrid living conditions and lack of proper nutrition that affected pregnant women, resulted in more than half of Black infants dying before the age of one. For enslavers, this represented an economic problem, particularly after the ban on the importation of enslaved Africans in 1808, as they desired to increase their wealth through enslaved women giving birth to children enslavers could use as laborers or sell. As a result, enslavers often hired physicians to increase the birthing of enslaved child.

The mortality rate remained higher for African Americans than whites beyond childhood. Mortality rates varied by location and by the type of plantation setting where people were situated; enslaved people died at higher rates on sugar plantations, common in southern Louisiana, than on cotton growing plantations in northern Louisiana and

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94 See Schwartz, Birthing a Slave.
elsewhere. A host of health problems afflicted survivors. A low-quality supply of food resulted in "protein hunger" and deficiencies in thiamine, niacin, calcium, Vitamin D, and magnesium. The cramped and poorly constructed slave cabins, contaminated water sources, and harsh working conditions exacerbated malnutrition, which led to higher susceptibility to disease and developmental problems. Many enslaved people suffered from rickets, bowed legs, dysentery, respiratory ailments, cholera, typhoid, worms (acquired due to working barefoot in the fields), skin problems, dementia, blindness, seizures, and swollen abdomens. The lack of recordkeeping at many plantations makes it difficult to know exact numbers, but scholars estimate that due to the high infant and childhood mortality rate, the average life expectancy for an enslaved individual came to only 21 to 22 years, compared to 40 to 43 years for white during the antebellum period.

After Louisiana became a U.S. territory, the territorial legislature passed their own Black Code in 1806, largely modeled after the earlier French regulations and existing customs, with a mixing in of new American-inspired provisions. Like the earlier codes, the 1806 Black Code contained the following provisions on medical care:

SEC. 4. Slaves disabled by old age, sickness or any other cause, whether their disease be incurable or not, shall be fed and maintained by their masters, in the manner prescribed by the second and third sections of this act, under the penalty of a fine of twenty-five dollars for each offence against this provision.

SEC. 5. It shall be the duty of the master to procure for his sick slaves all kinds of temporal and spiritual assistance which their situation may demand.

96 Covey, African American Slave Medicine.
The government rarely enforced these health care provisions. Instead, officials focused primarily on the 1806 code and subsequent additions to the code that increasingly restricted enslaved and free people of color, who made up over one third of the population. Under American rule, Louisiana attempted to change from the tri-caste system, with a large population of free people of color, to a binary of free and enslaved based upon race.\(^9\) Shaken by the Haitian Revolution, the 1811 German Coast uprising, and fears of abolition movements as the American sectional divide widened, white leaders created new policies that restricted the rights of free people of color. The 1806 Black Codes ended the right of coartación—self-purchase; denied all people of color the right to vote and serve in office or on juries; and made it illegal for an African American to insult or show disrespect to a white. An 1816 theater segregation ordinance followed. In 1830, an order claimed that all free people of color who had come to the city after 1825 had to leave. As white leaders attempted to calcify the racial apartheid in Louisiana, conditions for free and enslaved Blacks worsened.\(^1\)

However, enslavers had economic incentives to provide some medical treatment for enslaved people, due to the high costs of purchase. On plantations, when an enslaved individual became sick or injured, slave-owners had several options, all done at their discretion and with no consent from the enslaved person. The owner or the overseer could apply whatever basic treatment they knew to assist the person and they often relied on pamphlets like "Ewell's Planter's and Mariner's Medical Companion" and "Gunn's

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Domestic Medicine." Companies in New Orleans sold powdered drugs like ipecac and rhubarb; herbs; teas; and concoctions with names like "Speed's Tonic" and "Minor's Magic Fever Cure" for slave-owners to administer.\(^{101}\)

Enslavers could call upon an enslaved individual who had some knowledge of medicine—often folk medicine—from their plantation or a neighboring one. Black men and women used folk medicine they had learned in Africa before slavery—including Cesarean birthing and inoculation for smallpox—or from other enslaved members, passed down orally. Black women—especially older women referred to as "grannies"—predominantly served in this role, and functioned as midwives for fellow slaves and even white women. However, many enslavers worried about allowing enslaved individuals to occupy positions of knowledge and power like healers and refused to utilize their skills.\(^{102}\)

Many plantations had a space that was used as a "hospital" for the sick or injured. Most were poorly constructed and unhygienic.\(^ {103}\) William Howard Russell described one such "hospital" he visited on a sugar plantation outside of New Orleans in 1861. It was owned by the state's governor, Andre Bienvenue Roman. An enslaved, older African American woman ran the space, which held several beds in "naked rooms." Five patients occupied the hospital when he observed it. He described the patients, who:


\(^{102}\) Covey, African American Slave Medicine, 36. Fett, Working Cures.

sat listlessly on the beds, looking out into space; no books to amuse them, no
conversation—nothing but their own dull thoughts, if they had any. They were
suffering from pneumonia and swelling of the glands of the neck: one man had
fever.\textsuperscript{104}

Slave owners could request a physician come to the plantation; some owners had
yearly contracts with a specific physician. However, few physicians possessed formal
education in medicine, and often relied on traditional practices like bloodletting that only
worsened afflictions. The lack of success, and costs, prevented many owners from
employing physicians. Finally, in the early nineteenth century, enslavers could send
enslaved individuals to a growing number of "slave hospitals" that proliferated in New
Orleans. The growth of these institutions—explored in the following chapter—would
help strengthen the ties of the nascent medical field to slavery, further creating an
apartheid health care system.

\textsuperscript{104} William Howard Russell, \textit{My Diary North and South} (Boston: T.O.H.P.
Burnham, 1863), 258.
CHAPTER 2: THE GROWTH OF THE SLAVE-BASED HEALTH CARE ECONOMY, 1800-1861

Introduction

In April 1860, Dr. Erasmus Darwin Fenner wrote a brief notice in the seventh volume of the *New Orleans Medical News and Hospital Gazette*. Fenner discussed the Museum of the New Orleans School of Medicine, which he co-founded in 1856 as the city's second medical school—the University of Louisiana started first in 1834. Fenner detailed the "valuable specimens" sent to the museum by physicians in the region. He highlighted "the foot of a negro, a perfect specimen of elephantiasis" contributed by a Dr. D.R. Cole, who also submitted a "uterus in state of fibrous degeneration." Fenner also noted intestines, a mole, and a placenta contributed by three other physicians, and "a large number of diseased organs collected by Professor Flint and others from that inexhaustable storehouse—Charity Hospital." Most of the "specimens" Fenner described came from the bodies of enslaved men and women, taken by physicians after their deaths and submitted to the medical school for display and anatomy lessons for students. This practice, and many other cases of exploitation of and profit from Black bodies, helped fuel the success not only of the New Orleans School of Medicine, but of the larger medical system in what would become known as the "medical metropolis of the South."

While chapter one examined the ways that the nascent medical profession supported the institution of slavery, this chapter details how the institution of slavery permitted the growth of the health care system in the antebellum period, including private

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hospitals, the state-administered Charity Hospital, the two medical schools, and the practices of individual physicians. Private infirmaries called "slave hospitals" proliferated, buoyed by profits for providing care for enslaved individuals, paid by their enslavers. While not considered a "slave hospital," Charity Hospital strengthened its connections to slavery. The hospital continued to treat the increasing number of arriving enslaved people suffering from illness and bound for the slave market, owned and sold enslaved laborers, and derived income from donations from large enslavers. This chapter also explores the growth of the medical schools and the emergence of New Orleans as the "medical metropolis of the South," a process deeply connected to slavery. Physicians derived prestige and wealth through exploitation and experimentation on enslaved people, and passed down ideas of scientific racism to the next generation of doctors. Finally, this chapter examines the origins of an alternate source of health care for Black New Orleanians, Black doctors and lay healers.

**Private Hospitals and Slavery**

When enslaved individuals suffered from medical problems, enslavers could bring them to a hospital or clinic in New Orleans; other major southern cities like Charleston, Mobile, and Savannah had hospitals that provided care for enslaved people. In the first half of the nineteenth century, private hospitals began to flourish in New Orleans, part of an expanding political economy of slave health care. Part of the impetus for the growth in private hospitals came from white patrons who wished to avoid using Charity Hospital, which continually suffered from a poor reputation due its overcrowding. They knew that

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at Charity there was mixing of patients with minor health problems and those suffering from contagious diseases and high mortality rates, which regularly exceeded 20% annually in the period.\textsuperscript{107} Beginning in the early nineteenth century, private physicians began operating clinics that skirted the city's earliest area, on the border of the French Quarter and in the Treme and Central Business District neighborhoods. Beyond the patronage of wealthy white patients for their own health care, the private physicians and hospitals depended heavily upon enslavers and slave traders for financial support. In slave trading ports like New Orleans, the institution of slavery created economic opportunities for physicians. Some doctors advertised directly in newspapers and offered their services to enslavers, and they viewed the work as a steady source of income.

As the slave-based economy and the ensuing wealth of Louisiana grew in the antebellum period, slave hospitals proliferated. At many of these institution that emerged as the slave economy grew, enslaved people made up a large percentage or even a majority of patients, and were kept in separate spaces from whites.\textsuperscript{108} In 1835, Dr. C. A. Luzenberg opened the Franklin Infirmary across from the Pontchartrain Railroad station, with the first floor containing private rooms for whites for five dollars per day; the second floor, with a ward for whites for two dollars a day; and the third floor, a ward for the care of enslaved people, with their care paid for by owners at a charge of one dollar per day.\textsuperscript{109} In 1839, Dr. Warren Stone started his own infirmary based out of his home on the corner of Canal and Claiborne streets with a Dr. W.E. Kennedy. The hospital had the

\textsuperscript{107} Rudolph Matas, \textit{History of Medicine in Louisiana} (Baton Rouge: Louisiana State University Press, 1962), 201.
\textsuperscript{109} Matas, \textit{History of Medicine in Louisiana}, 229.
same layout as the Franklin Infirmary, with white private rooms on the first floor, a white ward on the second, and a ward for enslaved people on the third, charging the same rates as his colleague. By 1860, enslaved individuals made up nearly 62% of patients.\(^{110}\) In 1852, the Sisters of Charity began to administer the hospital, renamed the Masion de Sante.\(^{111}\) In 1858, the Sisters moved to a location on Tulane Avenue, several blocks from Charity, and opened their own separate hospital named the Hotel Dieu, with the same setup—white rooms, a white ward, and an enslaved ward on ascending floors—as the Franklin and Stone's infirmary.\(^{112}\) During the hospital's first five years in its new location, more than a third of the patients seen there were enslaved people.\(^{113}\) Slave traders too were significant clients, bringing in 22.6% of the enslaved patients.\(^{114}\) In 1841, Dr. G.W. Campbell, Dr. J Monroe Mackie, Dr. Stanford Chaille, and Dr. Alfred Mercier opened the Circus Street Infirmary in Faubourg Ste. Marie (later known as the Central Business District), adjacent to the French Quarter, with a ward and private rooms for enslaved patients.\(^{115}\)

These private hospitals shared several things in common. Physicians that were founders and teachers at the city's first two medical schools—discussed in the next section—started the clinics, a reflection of the burgeoning community of medical professionals in New Orleans. Almost all these doctors had worked at Charity Hospital, which gave the physicians opportunities to develop their reputations and a network of

\(^{110}\) T. G. Richardson, "Report of Stone's Infirmary, for the year ending August 31\(^{st}\), 1860," *New Orleans Medical and Surgical Journal* 7, no. 18 (1861), 201-224.


\(^{112}\) Matas, *History of Medicine in Louisiana*, 230.


\(^{114}\) Kenny, "Slave Hospitals," 37.

\(^{115}\) Matas, *History of Medicine in Louisiana*, 231.
clients during two-year residencies, but offered little or no financial compensation for their services, except for the position of house surgeon. Instead, they made their money by starting private practices and private hospitals for paying clients including enslavers, a steady source of income that allowed the hospitals to survive and the physicians to become wealthy. Through this wealth and status, physicians purchased large homes, and attained positions of political power including sheriffs, states representatives, and senators in Louisiana and in other southern states.

Touro Infirmary was the largest of the "slave hospitals," and perhaps most demonstrated the connections between medical institutions and the slave economy. Philanthropist Judah Touro founded the space in 1852, after purchasing the Paulding Mansion in the Warehouse District along the river and converting it into a 28-bed infirmary. When Touro died, his will bequeathed funding to sustain the hospital, noting that the infirmary was "designed as a charitable institution for the relief of the indigent sick." Many of the earliest patients included traveling seaman. Although primarily designed for indigent patients, Touro also admitted paying patients, including enslaved individuals with care paid for by enslavers. 116 From January 1855 to April 1861, nearly 52% of Touro's patients were enslaved people in a segregated space. 117 Enslaved people suffered from a mortality rate of 6.3% compared to a white mortality rate of 23.4% at Touro during the period, at first a seemingly remarkable gap, considering the general overall poorer health of the former. However, this difference illustrated the financial calculus that enslaver applied to medical care for enslaved individuals. As detailed by

117 Pritchtt and Yun, "The In-Hospital Mortality," 5.
economists Jonathan Pritchett and Myeong-Su Yun, the mortality reflected two main factors. First, many of the white patients were newly arrived immigrants suffering from yellow fever. In contrast, most enslaved individuals suffered from diarrhea and dysentery, respiratory afflictions, and accidents. Pritchett and Yu argue that enslavers usually only sent to hospitals enslaved individuals that they expected to recover, not those they expected may die, in comparison to many whites fatally suffering from yellow fever.

With a median stay of nine days and an average stay of 14 days at a cost of one dollar per day plus other expenses, enslavers were loath to pay for care. Additionally, the justified fear of an individual becoming ill or dying from a stay in the hospital—Touro's overall mortality rate exceeded 15% in the period—made the financial expenditure even riskier. However, enslavers also had to weigh the potential financial losses, including lost labor and the initial investment or cost of replacement. The cost for enslaved, prime-aged male in New Orleans in 1860 was $1800 dollars, the equivalent of over $50,000 dollars today.118 Like at Hotel Dieu, a dozen major slave traders were significant clients of Touro. Thomas Foster had 61 enslaved individuals treated at the hospital in 1857 and 1858; A.O. Sibley, 36 in 1857; and Bernard Kendig 25 from 1855-57.119

Dr. Joseph Bensadon, the hospital's chief surgeon and formerly Judah Touro's personal physician, brokered the hospital's relationships with slave traders, and exemplified the economic opportunities for physicians with the institution of slavery.

Prior to his role with the hospital, the firm of Walter Campbell, a large slave trader in the

city, paid Bensadon to treat enslaved individuals they sold and testify on their behalf in court cases when sued for violation of redhibition policies. When Bensadon became chief surgeon at Touro, the doctor brought his connection with the firm to the hospital, as Campbell brought enslaved people to Touro for treatment prior to auction. Bensadon provided certificates for slave traders like Campbell that attested to the health of enslaved individuals as part of the redhibition guarantees. Bensadon also worked part-time as a medical examiner for the U.S. Life Insurance, Annuity and Trust Company; in this capacity, he conducted exams on enslaved individuals—at a rate of $2.50 per exam—for slave-owners' insurance policies. Through his treatment of enslaved individuals on the behalf of slave traders and owners, Bensadon advanced professionally and became wealthy, and helped the hospital remain financially solvent. Even after Judah Touro's endowment ran out and the hospital provided many indigent patients with free care, Touro Infirmary prospered due to the payments from slave owners and traders; like other private hospitals, Touro likely would not have survived if not for the income from the slave system.\textsuperscript{120}

\textbf{Charity Hospital and Slavery}

Although private hospitals flourished in the American period, Charity Hospital remained the largest hospital in the city, and maintained its ties to slavery during this time. In 1811, Almonaster's daughter Anne formally renounced her family's rights to the hospital, turning it over to the control of the state legislature, which ordered construction of a new hospital after a fire destroyed the previous building in 1809. The new hospital first existed on Canal street, bounded by Burgundy, Common, and Dryades Streets. In

\textsuperscript{120} Kenny, "Slave Hospitals," 46.
1831, the hospital moved to its lasting location on Common, Howard, and Freret streets in what became known as the Tulane Gravier neighborhood.\textsuperscript{121} Overcrowding problems persisted in the new hospital requiring continual expansion in the following decades. When it opened in 1832, administrators estimated the space could hold 400 patients; by 1849, that number had been increased to 1,000 patients. In 1833, the Board of Administrators asked the Sisters of Charity, a religious order based out of Maryland, to manage the hospital and serve as nurses.\textsuperscript{122} Like the other hospitals, Charity's connections to the slave system grew in the first half of the nineteenth century, although its ties were often more indirect than institutions like Touro and Hotel Dieu. Charity Hospital treated some enslaved patients, although the number of Black patients rarely exceeded 1% of the total number of users. Most of the enslaved individuals received care at Charity due to city ordinances which mandated that all enslaved people would be inspected for contagious disease on arrival and treated at Charity, designated the official hospital for all individuals suffering from contagious disease, Black or white.

Beyond treating recently arrived enslaved individuals, Charity maintained ties to the slave system through medical care for white laborers and sailors. From the 1830s through the Civil War, many of Charity's patients were recently arrived immigrants, many of whom found work in expanding the levees, canals, and other infrastructure projects, or in the warehouses and docks in the city that had become what historian

\textsuperscript{121} The Jesuits originally owned the land, until their expulsion in 1763, and private landowners—including Jean Gravier—subsequently owned it until its sale and conversion into a faubourg in the 1840s, with lots subdivided and sold in the ensuing years. At the time, though, the space was largely undeveloped and considered out of the main city core.

\textsuperscript{122} Salvaggio, \textit{New Orleans' Charity Hospital}, 12.
Rashuana Johnson calls "Slavery's Metropolis." In 1840, 3,449 of the 4,404 patients were foreign-born, and more than two-thirds had resided in New Orleans for less than a year prior to admittance. Of the 955 patients United States born patients, only 34 came from Louisiana. Throughout this period, Charity also continued to provide care for thousands of sailors involved in the slave trade or the exportation of slave-produced agricultural goods, not just from New Orleans, but from throughout the country and the lager slave trading Atlantic World.

Charity was also connected to slavery in more direct ways. Charity's use of enslaved labor continued into the nineteenth century. The hospital purchased at least eleven, named enslaved individuals from 1817-1844. Hospital records also document Charity purchasing four enslaved individuals—names unknown—for $2,600 dollars in 1832, when the hospital moved into its larger home in the Tulane Gravier neighborhood; and owning an enslaved man named Andrew, valued at $1,200 from 1857-1862. Hospital administrators bought enslaved people from some of the city's largest enslavers and businessmen involved in the slave trade and slave-based economy. The hospital sold enslaved people as well. The 1849 annual report included the sale of three people for a total of $1,925 from July to August.

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123 Johnson, *Slavery's Metropolis.*
124 "Charity Hospital Annual Report 1840," Charity Hospital Collection, Rudolph Matas Library of the Health Sciences, Tulane University (Hereafter referred to as RMTU).
125 Charity Hospital Papers, LSMHC.
126 Andrew presumably either fled or was freed with the city's capture by Union troops in 1862. Board of Administrators Report 1832, RMTU. Board of Administrators Reports 1857-1861, RMTU.
127 "Charity Hospital Board of Administrators Annual Report 1849," Charity Hospital Collection, RMTU.
Additionally, the hospital derived income from donations by slaveowning benefactors. Jean Etienne de Bore, the first American mayor of New Orleans, a large slaveholder and a plantation owner who ignited the production of sugar cane in Louisiana in 1795, bequeathed $1,000 to the hospital. The 1824 will of Julien de Lallande Poydras, a chief political figure in the American purchase and early government of Louisiana, and the owner of multiple plantations and many enslaved people, donated real estate that the hospital sold for $35,000. John Burnside, a wealthy Irishman who owned the largest home in the city, multiple sugar plantations, including the 12,000 acre Houmas plantation, and more than 750 enslaved people, gave $10,000.\textsuperscript{128} In 1850, Stephen Henderson donated the Union Cotton Press to the hospital, which allowed the hospital to lease out the property for a steady source of annual income.\textsuperscript{129}

One of the most complex ways that Charity financially benefitted from slavery is illustrated by a moment in 1818. In February 1818, Renato Beluche, a New Orleans-born Venezuelan privateer captured the Spanish slave ship \textit{Josefa Segunda}, which was sailing from Africa to Havana with more than 200 enslaved people onboard. Beluche sold some of the enslaved people in Cuba to purchase provisions, then the ship sailed for the Island of Margarita (off the coast of Venezuela), but was forced to stop in La Balize, Louisiana for supplies. An inspector of revenue from La Balize boarded and seized the vessel, claiming the ship was in violation of federal law (which went into effect in 1808) that banned the international importation of enslaved people to the United States. With the aid of a Navy ship, customs house officials brought the vessel and 175 enslaved people on

\textsuperscript{129} "Charity Hospital 1912 Annual Report," Charity Hospital Collection, RMTU.
board to New Orleans. Part of the 1807 federal law allowed states to enact their own laws that would stipulate how the state would deal with captured, enslaved people. Louisiana passed a law in March of 1818 that ordered enslaved people seized if vessels violated the 1807 federal law—including vessels not intended to land and sell enslaved people in the United States but "hovering on the coast" of the U.S. The people on board would be sold to the sheriff of Orleans Parish at auction, with half of the proceeds going to the captain of the capturing vessel, and the other half allocated to the Charity Hospital. Officials sent 152 enslaved individuals—23 had presumably died after the initial seizure in La Balize—to Dr. Flood, a Louisiana planter and physician. Flood held the group for 81 days, and put them to work in his fields. He later successfully requested $4,000 for housing and feeding costs associated with the seizure, and another $1,570 for providing medical care.

The Cuban owners of the vessel, the firm of Caricabura, Arrieta, and Company, came to New Orleans and filed suit for return of the vessel and the enslaved people, claiming its capture to be illegal and in violation of international law. Additionally, multiple individuals—Beluche, the naval officer involved in bringing the vessel to New Orleans, the customs collector in New Orleans, and the surveyor of the port of New Orleans—all filed claims to receive money from the upcoming sale. All the claimants pushed for immediate sale of the enslaved even before settling legal ownership as the value of the enslaved people decreased due to illness and death during the "seasoning period" on Flood's plantation. Charity Hospital too supported the immediate sale as it would earn half of the profit. The auction on July 30th earned $95,000—less $14,000 in costs like the physician’s charges and the planter's bill—for the 124 people sold. Two died awaiting sale, one ran away for certain and another 25 either died on or ran away
from Flood's plantation. There is a possibility that he had illegally sold some of his charges. The Louisiana courts ruled that the seizure was legal and the naval officer, the customs collector, and the port surveyor—could split half of the net of $81,000, with the other half—more than $40,000—going to Charity Hospital. The U.S. Supreme Court upheld the decision in March 1820 in the *Josefa Segunda* case (18 U.S. 338), although various parties contested the money and the later sale of the vessel itself for the following decade.130

Slavery provided vital in sustaining Charity Hospital in the decades preceding the Civil War. Money from the sale of the enslaved individuals in the *Josefa Segunda* case; financial support from large-scale enslavers; income from the cotton press; the use of enslaved people as laborers; and other ties to the slave system were central to its operations. Without this revenue, the institution likely would have closed as it regularly struggled to remain financially solvent. In 1843, for example, hospital noted in its annual report that it owed a cumulative debt of $79,898 dollars to creditors and vendors. The Board of Administrators that year and nearly every year asked for more funding from the

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The state legislature in this period never established a set amount to annually award the institution, and some years provided less than $1,000 dollars. Costs at the hospital soared in the late 1840s and 1850s with large-scale immigration from Europe, especially from Ireland—suffering from the potato famine—and Germany. Patient numbers, which had averaged $2,000-3000 annually in the early 1830s jumped dramatically in the following years, reaching a peak of 18,031 in 1852 as a result of immigration and the large-scale devastation of continuous epidemics of smallpox, cholera, and especially yellow fever, which killed tens of thousands in the period. To meet this increasing usage, the hospital relied on fluctuating sources like taxes on gaming licenses, fees for licenses for dances, money bequeathed in wills by dying patients, charges for patients that exceeded the maximum income threshold, and a tax imposed on passengers disembarking in the city. However, the financial support from the slave system proved to be the most steady and richest source of income.

Medical Schools and the "Medical Metropolis of the South"

Like the doctors and hospitals of New Orleans, medical schools established early connections to the slave system in the period. In 1834, seven young physicians—Dr. John H. Harrison, Dr. Thomas Hunt, Dr. Charles Luzenberg, Dr. J. Monroe Mackie, Dr. T. R. Ingalls, Dr. August H Cenas, and Dr. E. Bathurst Smith—founded the University of Louisiana (later Tulane University), the first medical school in the state, and one of fourteen opened nationwide in the 1830s, although many proved short-lived. Many young physicians—shut out of the more lucrative work at municipal hospitals, where positions were awarded through the political spoils system—started medical schools to financially

131 "Charity Hospital Board of Administrators Annual Report 1843," Charity Hospital Collection, RMTU.
support themselves. Money was probably the prime motivation for the young doctors in New Orleans.\textsuperscript{132} The founders stated in the annual circular that they started the school "with the express view of educating Southern physicians, and under the conviction that a more eligible site for a great medical school could nowhere be found." They argued that the city's qualities—low cost of living, "most healthful and agreeable climate from November to July," and status as the "great Commercial Emporium of one half of the Union"—made it the ideal location for a medical school.\textsuperscript{133}

The state legislature granted a charter to the Medical College of Louisiana in April 1835, and classes started that year. The school used several temporary locations, including for a time holding classes in Charity Hospital. In 1838, the institution added a school of pharmacy. In 1843, the state legislature granted a lot near Charity to construct their own building, and included the Medical College as the medical school for the newly created and state-funded University of Louisiana. In exchange, the medical college agreed that faculty and students would serve as attending physicians and surgeons at Charity Hospital for free for a period of ten years; the school also pledged to take one indigent from each parish per year. Beyond direct funding each year, the state legislature also appropriated $40,000 for construction costs in 1847 and $25,000 in 1850 for a museum.\textsuperscript{134}

Dr. Erasmus Fenner, a founding member of the American Medical Association and the editor for the \textit{New Orleans Medical News and Hospital Gazette}, along with

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\textsuperscript{132} Starr, \textit{Social Transformation of Medicine}, 44.  \\
\textsuperscript{133} "Annual Circular of the Medical College of Louisiana for the Session of 1838 & 1839," Stanford E. Chaille Papers, LRCTU.  \\
\textsuperscript{134} Stanford E. Chaille, "Historical Sketch, of the Medical Department of the University of Louisiana," 1861, Stanford Chaille Papers, LRCTU.
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several other local physicians—notably Dr. Samuel Choppin; Dr. Cornelius Beard; Dr. Anthony Peniston; and Dr. D. Warren Brickell—started a second school, the New Orleans School of Medicine, admitting students starting in 1856. To support the school, the state legislature appropriated $20,000. Like the University of Louisiana, all students—seventy-six the first year—trained at Charity, with professors having privileges at the hospital. Fenner foresaw great things for their school and the city. He posited that New Orleans would soon become the South's leading "medical center," and argued that a third school would join the existing two by 1867, with his own school having more than a thousand students.135

Fenner's prediction appeared to be coming true in the following years. By 1859, the University of Louisiana had 333 students and the New Orleans School of Medicine had 164 students, making them the 5th and 9th largest U.S. medical schools; New Orleans joined New York City and Philadelphia as cities having more two or more of the ten largest medical schools.136 By 1860, the New Orleans School of Medicine was the 7th largest medical school with 216 students hailing not just from Louisiana, but eleven other states and South America.137 The makeup of the student body at the University of Louisiana was similar.138 By 1861, the New Orleans College of Medicine educated

137 "4th Annual Circular and Catalogue of the New Orleans School of Medicine" June 1860, Stanford Chaille Paper, LRCTU.
138 Despite a ban on Black students, both schools regularly had South American students; for example, the New Orleans College of Medicine's first class featured Manuel Pio Avilla, writing a thesis on yellow fever, from Cuba and Ramon E. Reynier from Nicaragua. "Annual Report and Circular of the New Orleans School of Medicine," 1856, New Orleans School of Medicine Collection, RMTU.

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students, with another 400 enrolled at the University of Louisiana, the third largest medical school in North America at the time. More than 4,000 had matriculated at the latter since its opening in 1835. In the words of Dr. D. Warren Brickell, in the span of a few years, New Orleans had gone from a "fifth-rate point for medical students"—behind Louisville, Charleston, Augusta, and Nashville—to the "medical metropolis of the South."139 The transformation was deeply tied its simultaneous emergence as "slavery's metropolis." Both schools relied heavily upon state appropriations derived from the slave-based economy. Sons of enslavers made up large percentages of the medical students, providing the other source of income, tuition.

Funded by the slave system, these schools supported that same system in multiple ways. Both schools maintained the color line by refusing to admit Black students. At both New Orleans schools, instructors like Brickell, Fenner, Beard, and Peniston—all of whom published accounts of experiments on African Americans—taught lessons based on notions of scientific racism, used to propagate both the slave system and the apartheid medical system. As part of their training, instructors distilled ideas similar to Samuel Cartwright, on biological differences among the races, including lower levels of Black intelligence, higher levels of tolerance of pain, and immunity to diseases like yellow fever. From both school's inceptions, students learned anatomical lessons and practiced procedures on cadavers from Charity, mostly Black, and taken without seeking the consent of families.140

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139 D. Warren Brickell, "Introductory Lecture" November 8, 1857, Stanford Chaille Papers, LRCTU.
Taking things a step further in the macabre, at the New Orleans School of Medicine, Dean E. D. Fenner created a "museum" to display cadavers. Initially, Fenner purchased them from Europe, but starting in 1857 white physicians in the region began to send him cadavers and body parts of enslaved people, many of whom had displayed unusual medical conditions. For example, in August 1857 a Mississippi physician named Dr. John Butts shipped the arm of an enslaved Black woman that was suffering from elephantiasis. In his correspondence with Fenner, Butts stated that the disease would slowly kill the woman, but noted his excitement on discovering the case and wrote that he would be "pleased" to have Fenner's opinion on the noteworthiness of the case. Other white physicians followed suit, which allowed Fenner to amass a large collection.141

To give students an even greater advantage in their training, both schools offered the opportunity to practice on live patients at Charity, making them among the first medical schools nationwide to provide hands-on experience in a hospital. Administrators at both schools highlighted access to Charity Hospital as one the key draws for medical students. In his opening lecture to the incoming class of 1857, Brickell stated that Charity Hospital's greatest "resource" was its "superabundance of anatomical material": poor whites, but mostly enslaved and free people of color.142 The taught lessons of racial inferiority and the view of African Americans as "anatomical material" resulted in generations of physicians that imbibed and propagated these ideas. One example could be seen in dissection of Black bodies. White physicians in the period knew that many

142 D. Warren Brickell, "Introductory Lecture" November 8, 1857, Stanford E. Chaille Papers, LRCTU.
African Americans did not want the bodies of themselves, friends, or family dissected. Brickell noted in the *New Orleans Medical News and Hospital Gazette* in 1856 of the "utter abhorrence which negroes have for cutting up a dead body." Yet, the hospital continued to dissect Black bodies over their objections.

Many New Orleans physicians also experimented on enslaved people, and a large number of the city's doctors—and physicians from throughout the region—published these experiments in the *New Orleans Medical News and Hospital Gazette*, edited by D. Warren Brickell and E.D. Fenner. In June 1854, Charity's head surgeon, Dr. Samuel Choppin, attempted the nation's first blood transfusion on an enslaved person suffering from cholera. European physicians started carrying out blood transfusions in the 1850s, and Dr. Choppin witnessed one performed in Paris in early 1854. Despite only witnessing the procedure once, and never assisting in the complicated operation, Choppin tried a blood transfusion upon his return to New Orleans. During this trial, Choppin made four unsuccessful attempts of transfusing the blood, and his patient died. Nevertheless, Choppin published about the event in the *New Orleans Medical News and Hospital Gazette* to claim the first attempt of blood transfusion in the United States.144

In the same issue of the *New Orleans Medical News and Hospital Gazette*, Dr. A. P. Jones detailed his experiments on enslaved people suffering from smallpox on a plantation outside of the city. Jones detailed how he put ointment on half of one man's face and one hand to see if would prevent pitting—it did not work. With others, he tried different procedures to prevent pitting, including excluding light, applying nitrates of

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143 D. Warren Brickell, "Epidemic Typhoid Pneumonia Among Negroes," *New Orleans Medical News and Hospital Gazette* III, no. 1 (February 1856), 540.
144 Samuel Choppin, "Charity Hospital," *New Orleans Medical News and Hospital Gazette* I, no. 1 (March 1854), 19-20.
silver, and prescribing masks of oiled silk. Dr. Cornelius Beard, who ran the Beard Eye Infirmary, noted in July 1859 that he developed his procedure for the removal of cataracts by experimenting on enslaved people. In the July 1856 edition, H.J. Richard described the removal of a polyp from the uterus of an enslaved woman in Atchafalaya. Richard noted that the polyp itself had "nothing singular in its size or structure"; only the method of removal—using a silken cord—which deviated "from that recommended and normally practiced" made the case notable.

Like Richard's procedure, many of the experiments occurred on enslaved women. As argued by historian Deidre Owens Cooper, white physicians in the pre-Civil War period pushed for advancements in the fields of obstetrics and gynecology for white women by experimenting on enslaved women first. New Orleans's D. Warren Brickell was one significant example, and reaped great professional benefits. Brickell began his career as a visiting physician at Charity Hospital. While working there, he regularly carried out experiments on enslaved people, both men and women. In the February 1856 edition of the *Journal*, Brickell wrote of how he attempted to find a cure for typhoid pneumonia, which he noted "could only be attained by experiment." To this end, Brickell detailed the following he tried on enslaved Charity patients: bleeding, enemas, opium; brandy; carbonate of ammonia; and quinine—which he argued worked best. However, it was his experiments in the fields of obstetrics and gynecology that would lead to his greatest acclaim and career advancement. In November 1858, Brickell detailed in his

145 Cornelius Beard, "Resume of Practice, Hospital and Private," *New Orleans Medical News and Hospital Gazette* 5, no. 2 (July 1859).
146 "H.P. Richard, "Atchafalaya," *New Orleans Medical News and Hospital Gazette* 3, no. 2 (July 1856), 356.
147 Owens, *Medical Bondage*.
journal how he tested various treatments on several enslaved women for vesicovaginal fistula, a hole that develops between the vagina and bladder and leads to leaking of urine into the vaginal canal. He did so, he noted, because of his "surprise" when a fellow doctor informed him that a case of vesicovaginal fistula had never been cured in the city. Brickell considered the fact to be a "stigma on the profession of so large a city."

Although he noted that he had "no experience in the matter of operating" and had never even observed the procedures, Brickell nevertheless sought to remove the "stigma on the profession." He read about the works of other physicians, ordered medical instruments, and then he had to "get a case on which to operate." His first patient was an enslaved woman a slave owner allowed him to operate on in one of the city's private hospitals "considered incurable." Brickell noted that it was an "ugly case for a beginner," but he was "determined to try it." Brickell tried two methods made famous by other surgeons, notably a procedure advocated by J. Marion Sims which "had been known to the world."

Sims, who owned and operated the largest hospital for enslaved people in the state of Alabama, experimented with the method on twelve enslaved women—several of whom died—at his private hospital from 1845 to 1849. Upon finally reaching success, Sims published the procedure in 1852, and became revered as a medical pioneer as the "father of gynecology," although many contemporary scholars have criticized Sims for his operations on enslaved women without their consent and his refusal to administer anesthesia to patients.¹⁴⁹

Like Sims, Brickell did not administer anesthesia, and like Sims's early work, he "failed signally." Brickell then tried a method advocated by Nathan Bozeman, a rival of Sims who pushed for another way to repair fistulas that he too had developed through experimentation on enslaved women in Montgomery. This too failed and Brickell "abandoned" the woman, thinking her "incurable" and likely to die. The slave owner brought her to Bozeman, who successfully operated; Bozeman later moved to New Orleans in 1859, working as a visiting surgeon at Charity and operating the Bozeman Hospital for the Disease of Women, where he too continued to experiment on enslaved women. Brickell, after two other failed attempts, finally succeeded on his fourth patient. After three more successful efforts on enslaved women, and feeling confident after he had practiced on enslaved Black women, Brickell operated for the first time "on a very respectable white woman" in 1859. Brickell continued to experiment on Black women, for example trying a new method for draining an ovarian tumor on a free woman of color in March 1858. She died, which he blamed on the woman waiting too long for medical treatment. He then attempted the procedure again in April 1858, with success, on an enslaved woman. Brickell parlayed his experiments into a highly successful career, including his role as co-editor of the Medical News and Hospital Gazette, co-founder and professor at the New Orleans School of Medicine, and as a Professor of Obstetrics. In many ways, Brickell was one of the leading pioneers in the field of gynecology and obstetrics. The New Orleans School of Medicine's first annual report in 1856 proudly highlighted that the school was one of the first in the country to offer coursework in

150 D. Warren Brickell, "Two Cases of Vesico Vaginal Fistula Cured," New Orleans Medical News and Hospital Gazette 5 (November 1858), 579.
151 D. Warren Brickell, "Veso Vaginal Fistula," New Orleans Medical News and Hospital Gazette 6, no. 1 (January 1859), 159.
obstetrics and the "diseases of women," taught by Brickell, and largely based on the procedures he attempted and perfected on Black bodies. He and Fenner, who carried out his own experiments on enslaved women, also provided medical advice—for a fee—to enslavers on methods of "breeding" enslaved people, which again shaped his teaching of obstetrics.  

Physicians like Brickell, Fenner, Beard, and others saw no problem on experimenting on enslaved people. They were leading proponents of ideas of Black racial inferiority, and even status as sub-humans. Many saw the high rates of disease and mortality—caused by the very system of slavery they justified—as proof of the African and African American inferiority and justification for slavery. These same men instilled these lessons to the subsequent generations of physicians through their positions at the University of Louisiana and the New Orleans School of Medicine, ensuring this self-reinforcing cycle of medical apartheid, of Black exclusion and in some cases experimentation, and the larger system of white supremacy would continue after the end of slavery through the twentieth century. The medical knowledge discovered in the antebellum period was crude at best. Supposed "cures" were usually dangerous and often lethal. For example, the practice of bleeding—to restore desired balances of bodily liquids; the application of mercury; and the use of silver nitrate all led to further problems or death. In this period, prior to the development of germ theory and the creation of vaccines and antibiotics, medicine remained crude and dangerous.

Yet, as physicians offered cures that made health conditions worse or killed patients, they castigated others for their own attempts at treatment, including slave

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152 Schwartz, Birthing a Slave, 278.
owners, midwives, and folk or lay healers. In the same article in which he described his myriad of attempts to cure typhoid pneumonia—including bleeding, which only weakened sufferers and may have facilitated death, and opium—D. Warren Brickell lambasted plantation owners for trying to cure the medical problems of enslaved people themselves. Brickell said of these slave owners and overseers: "their knowledge is complete, or, at any rate, sufficient in their own estimation, to warrant such efforts for the restoration of the sick man as they would not, on any account, have exerted on the simple and comparatively worthless cart wheel." Ideas about physicians' superiority and self-importance littered the writings that appeared in the New Orleans Medical News and Hospital Gazette. Writing in an editorial in 1855, Brickell and Fenner wrote of how enslaved people viewed white physicians with respect and practically as deities. The two wrote: "As he (a physician) plies his toilsome way, there is not a negro he meets but has a ready bow and grin for him whom he looks upon as akin to the Gods, as his doctor and special friend." Furthermore, they argued that physicians like themselves worked harder than the enslaved people they provided care to: "The veriest slave toiling in the galleys or in the mines has not a more laborious task than he." These statements fed into a notion of physician paternalism akin to that espoused by the enslavers themselves, with doctors as benevolent and almost heroic figures, and enslaved people as fortunate recipients. The writings also failed to even briefly address potential Black fears or mistrust, other than acknowledging African American desires to prevent dissection.\footnote{Brickell, "Typhoid Epidemic," 540.} \footnote{D. Warren Brickell and E.D. Fenner, "Editorial," New Orleans Medical News and Hospital Gazette 2 (1855): 40.}
The results of these medical practices—of medical students practicing on Black bodies, gazing at Black bodies and body parts in the anatomical lessons and the anatomical museum, of white physicians dissecting Black bodies purposefully against the wish of the deceased's friends and families, of white physicians experimenting on enslaved patients—had several significant results. First, they greatly benefited the physicians as individuals and as a profession. These practices helped turn what had often been seen as a largely unorganized, non-lucrative, and part-time pursuit—many doctors in the colonial period were either wealthy or had other careers to support their medical endeavors—into a profession that provided wealth and social status by the mid-nineteenth century. Black bodies and body parts were the "anatomical material" for medical students. Enslaved individuals were the "anatomical material" for experiments that physicians used—only after perfecting them, often with no regard for the pain and death of their African Americans patients—to enhance their reputation and draw wealthy, white patients.

The hundreds of physicians that graduated from the University of Louisiana and the New Orleans School of Medicine in the decades before the Civil War would work at Charity Hospital, Hotel Dieu, Touro Infirmary, and the private "slave hospitals," providing medical care for enslaved people and the sailors and working class members of the slave-based port economy. As physicians hired by nearby plantation owners, they treated enslaved people and offered advice to enslavers on how promote reproduction of enslaved people. As medical consultants, they helped slave traders achieve the highest sale price in the city's slave markets. As medical examiners for insurance companies, they backed life insurance policies taken by enslavers on enslaved individuals. As private
physicians, they cared for whites who gained great wealth from the slave economy. These roles became even more important in first half of the nineteenth century as the value of enslaved people increased with expanding slave-based economy and the end of the international slave trade to the United States. The medical establishment in New Orleans played an integral role in supporting the system of slavery, and in turn, the slave system played an integral role in supporting the medical establishment. Both benefitted from each other, and both grew in the period due at least partially due to the other.

Black Health Care

While both the medical establishment and the supporters of the slave system benefitted from this reciprocal relationship, African Americans, both free and enslaved, suffered. As previously detailed, enslaved individuals suffered from numerous health problems due to the conditions of slavery. For enslaved people, the financial interests of the enslaver primarily dictated the medical care they received. Due to neglect and fear of white physicians and enslavers, enslaved individuals provided care for themselves. On plantations, enslaved Black men and women used folk medicine they had learned in Africa before slavery—including plant-based and herbal remedies, Cesarean birthing, and inoculation for smallpox—or from other enslaved members, passed down orally. Black women—especially older women referred to as "grannies"—predominantly served in this role, and functioned as midwives for fellow slaves and even white women. Medical care also often involved spiritual elements like prayers, charms, songs, and conjuring.¹⁵⁵

¹⁵⁵ Fett, Working Cures, 58. Covey, African American Slave Medicine, 43. African Americans also used medical knowledge as a form of resistance. Some enslaved individuals feigned illness to purposely slow down work; get needed rest; or spend time with family. Unfortunately, primarily focused on getting as much production as possible, slave owners often suspected slaves of making up illnesses even when truly sick, forcing
African Americans also provided care for themselves in New Orleans. Most physicians and hospitals refused to treat free people of color, who made up 34.6% of the city's population in the 1810 census. Some free people of color worked as physicians, providing care for other members of their community. James Durham is believed to be the nation's first Black physician. Durham was born in Philadelphia in 1762. As a child, his first owner sold him to Dr. John Kearsley, Jr., a throat specialist who trained Durham and used him as an assistant in treating patients; Durham was still an adolescent at the time. When Kearsley died in 1777, a British surgeon, Dr. George West, eventually became Durham's owner. Durham worked under West as a physician's assistant. Eventually, West sold Durham to Dr. Robert Dove of New Orleans. Durham continued his medical training under Dove, and bought his freedom in 1783 for five hundred pesos. Durham established his own medical practice in the Spanish-controlled city, treating both white and Black patients, earning an estimated $3,000 a year, placing him among the city's wealthiest residents. Durham briefly returned to Philadelphia in 1788 where he befriended Dr. Benjamin Rush, a leading physician, Founding Father, and opponent of slavery. In speeches and letters in support of abolition, Rush held up Durham as an example of the intelligence and capability of African Americans. "I expected to have suggested medicines to him; but he suggested many more to me." Durham moved back to New Orleans and continued his work.

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Orleans in 1789, where he continued to practice medicine until at least 1802. Although Durham saved many patients from yellow fever outbreaks in 1794 and 1800, new Spanish rules permitted him to only treat throat ailments in 1801 due to his lack of a formal medical degree. After 1802, Durham either moved—some speculated he returned to Philadelphia—or died, as his record trail ends in that year.\textsuperscript{157}

Several other Black doctors followed Durham, although few in number. The first free person of color from New Orleans to earn a medical degree was Dr. Alexandre Chaumette. Chaumette studied medicine and interned in Paris in the 1840s, and returned to New Orleans in 1845. Although no law existed at the time mandating an examination prior to be allowed to practice in medicine in Louisiana, white physicians required that Chaumette be subjected to one, an obligation not required of white doctors.\textsuperscript{158} Charles Louis Roudanez was another prominent Black physician. His mother, Aimee Potens, was a free woman of color, born to an enslaved woman in Saint Domingue. She fled the Haitian Revolution, and gave birth to Charles Louis in Louisiana in 1823. After her husband's death, Potens, considered within her community to be a healer, moved with her children to New Orleans. Although his baptismal record noted his race as white (his father was a French merchant), Roudanez identified his entire life as a person of color. Roudanez received his early education in New Orleans, and earned a considerable amount of money through investments in municipal bonds. He then traveled to Paris, where he earned a medical degree at the Faculty of Medicine of Paris in 1853. Returning

\textsuperscript{157} Charles E. Wynes, "Dr. James Durham, Mysterious Eighteenth-Century Black Physician: Man or Myth," \textit{The Pennsylvania Magazine of History and Biography} 103, no. 3 (July 1979): 325-333.

\textsuperscript{158} A.P. Tureaud and C.C. Haydel, "The Negro in Medicine in Louisiana" (1935), 3, A.P. Tureaud Collection, Amistad Research Collection (Hereafter referred to as ARC).
to the United States, he earned a second medical degree at Dartmouth University in 1857
and returned to New Orleans to open a prosperous medical practice, reportedly with both
Black and white patients.\textsuperscript{159} Oscar Guimbilotte too earned a medical degree in Paris, and
opened a practice in New Orleans in 1858. At least two Black pharmacists—Eugene
Grambois and Joseph Llado—operated drugstores prior to the Civil War.\textsuperscript{160}

Black doctors like Durham, Chaumette, Guimilotte, and Roudanez were
exceptions, though. Few opportunities to train in the United States existed—David Peck
became the first graduate of an American medical school, Chicago's Rush Medical
School, in 1847. This led the handful of Black physicians to mostly seek training in
Europe—following James McCune Smith, who became the first African American
medical school graduate in 1837 with a degree from the University of Glasgow—a costly
venture. Additionally, the high cost of their services meant their clientele was
predominantly wealthy Creoles, mostly omitting free people of color of limited means.
This latter group suffered from some of the same health problems that afflicted enslaved
people on plantations, including malnutrition and tuberculosis due to poor living
conditions; most lived in low-quality housing in the "back part of the town," closer to the
swamps and more flood-prone, or near the wharves.\textsuperscript{161} They also worked on jobs that
exposed them to greater risks of injury.\textsuperscript{162}

\textsuperscript{159} "The History of Flint Goodridge Hospital," 3, Marcus Christian Collection,
UNO. Mark Charles Roudanez, "Grappling with the Memory of New Orleans," \textit{The
\textsuperscript{160} Tureaud and Haydel, "The Negro in Medicine," 4.
\textsuperscript{161} Richard Campanella, "An Ethnic Geography of New Orleans," \textit{The Journal of
\textsuperscript{162} See Thomas C. Buchanan, \textit{Black Life on the Mississippi: Slaves, Free Blacks,
and the Western Steamboat World} (Chapel Hill: University of North Carolina Press,
2006).
Many free people of color utilized Black folk and spiritual healers, with perhaps the most famous being Marie Laveau, the so-called "Voodoo Queen" of New Orleans. Born as a free person of color—the daughter of a plantation owner and his mistress—Laveau rose to prominence as hairdresser for the wealthy, and also for providing nursing care. Laveau became a practitioner of voodoo, a syncretism of Catholicism and West African folk beliefs, part of the Afro-Creole culture that developed in Louisiana.\textsuperscript{163} She sold powders created from herbs and roots to cure afflictions and claimed to be able to heal the sick. Through her role as a "voodoo queen," Laveau occupied a position of social prominence, and reportedly had thousands of followers and clientele, both Black and white, who used her medical services, including business leaders, planters, and politicians.\textsuperscript{164}

Most white physicians viewed Black physicians, healers, and midwives with both scorn and also as potential competition for their services. E.D. Brickell complained in an 1857 article in the \textit{New Orleans Medical News and Hospital Gazette} of Black midwives, who he considered to the "curses of communities in which they are found."\textsuperscript{165} Similarly, in an 1860 article entitled "Quackery Rampant" in the same journal, Dr. Cornelius Beard noted that "the sick of high and low degree flock for relief" with folk healers. He warned

\begin{quote}
\textsuperscript{165} D. Warren Brickell, "Two Cases of Vesico Vaginal Fistula Cured," \textit{New Orleans Medical News and Hospital Gazette} 5 (November 1858): 579.
\end{quote}
that the city was "infested with these miserable imposters" and that prescriptions made by Black healers would either provide no cure or potentially make the ailment worse.\(^{166}\)

The role of Black physicians, healers, and midwives was not just a problem for white physicians fearing the competition. Their positions of knowledge, power, and wealth threatened the apartheid system that rested upon notions of Black inferiority and white supremacy. Thus, whites required Black but not white physicians to pass examinations to practice medicine starting in the 1840s, as part of an effort to curtail their professional success; some southern states like Virginia banned Black doctors altogether.\(^{167}\) As sectionalism spread during the antebellum period, and the abolition movement grew, New Orleans increasingly restricted Blacks. In 1840, the city banned whites and enslaved Blacks from attending balls for free people of color and prohibited interracial baseball games. In the following two decades, the city banned interracial gambling; ended emancipation of any kind in 1857; banned free people of color from owning businesses that sold alcohol; required segregation of brothels; and increasingly pushed for residential segregation.\(^{168}\)

As a result, many free people of color also left New Orleans, fleeing the increasing restrictions. From a peak 23,400 in 1840, by 1860 only 11,800 free people of color resided in New Orleans, down from a high of 36% of the population to less than 7 percent.\(^{169}\)

\(^{166}\) Cornelius Beard, "Quackery Rampant," *New Orleans Medical News and Hospital Gazette* 7, no. 1 (January 1860): 394.
^{167} Savitt, *Medicine and Slavery*.
^{169} Date computed from population percentages estimated by Fussell, "Constructing New Orleans," 847 and census statistics from the 1810-1860 U.S. Census.
Nevertheless, free people of color in New Orleans faced significantly better conditions than Black Americans, free or enslaved, in most other parts of the United States in the antebellum period. Until 1856, Black residents had a lower mortality rate than whites.170 As noted by historian Kathryn Meyer McAllister Olivarius, yellow fever may have played a significant role. Biologists Lauren Blake and Mariano Garcia-Blanco found that whites in the nineteenth century south were 14.6% more likely to die from yellow fever than non-whites in that period.171 "Unseasoned" immigrants, having no previous exposure to the disease, died at the highest rates. Thus, the large influx of immigrants in the 1830s and 1840s to New Orleans, a population that died from yellow fever at high rates, may have significantly lowered the overall white life expectancy in New Orleans—immigrants made up 55.7% of the white population of New Orleans in 1850. Additionally, due to the legacy of less restrictions on manumission and Black wealth property ownership, free people of color—who made up 23% of the city's population in 1840—had 23% of the city's wealth.172 Still, the longer life expectancy for free people of color is remarkable. By the end of the Civil War, this would change dramatically, and the Black mortality rate would reach double that of whites as apartheid health care become further institutionalized, all explored in chapter three.

170 "1884 Annual Report Louisiana State Board of Health."
CHAPTER 3: THE CIVIL WAR, RECONSTRUCTION, AND THE RISE OF JIM CROW HEALTH CARE, 1865-1900

Introduction

On July 3rd, 1864, an enslaved woman named Valerie entered the Hotel Dieu Hospital. Valerie's enslaver was Christopher Toledano, a wealthy cotton broker in New Orleans and president of the Merchants Insurance Company. Suffering from an unknown ailment, Valerie stayed at the hospital for 23 days, with Toledano paying for her treatment at a cost of 23 dollars. On July 25th, the hospital released Valerie to return to her enslaved labor.173

Valerie's case is notable due to her status as the last documented enslaved person treated at a New Orleans hospital. When Valerie entered the hospital on July 3rd, delegates were meeting to discuss a new state constitution. That constitution, adopted on July 22nd, formally abolished slavery in the thirteen Union-held parishes of Louisiana, although it did not go into effect until approved by voters in September. The end of Valerie's treatment marked the end of the practice of "slave hospitals" in New Orleans. Valerie was also one of the last Black patients treated in a private hospital until integration a century later.

This chapter examines one of the "crucial turning points" in the city's health care history. During federal occupation of New Orleans, an opportunity existed to end apartheid health care. While Louisiana abolished slavery in 1864 and enfranchised Black voters, neither state nor federal officials enforced "public rights" by requiring integration

173 "Hotel Dieu Hospital Patient Registers 1858-1900," Hospital Records Collection, CANOPL.
of hospitals. Instead, the federal government created the short-lived and underfunded system of Freedmens Hospitals for Black patients, which ended in 1869. From 1868-1877, Charity Hospital desegregated. However, with the end of Reconstruction and return to power of the Redeemers, medical leaders purposely chose to institutionalize apartheid health care, with private hospitals and the University of Louisiana refusing to accept Black patients or students, and Charity Hospital treating Black patients in separate wards. Excluded from health care, and subject to many other aspects of discrimination, the racial health gap widened dramatically. This chapter also examines the early, unsuccessful attempts to create Black medical schools in New Orleans in the 1870s and 1880s, and the final successful creation of the Flint Medical College in 1889, and Flint Goodridge Hospital in 1896.

Health Care in Crisis and the Freedmen's Hospital

The Civil War and ensuing federal occupation of New Orleans caused significant changes in New Orleans, seen in the disrupted and shrunken health care field. Many hospitals closed, and the number of physicians and medical students declined dramatically. E.D. Fenner's vision of New Orleans as a medical center would have to wait until the following century to reach fruition.

Changes in the medical field occurred as soon as the Civil War started. As members of the city's wealthier class and defenders of white supremacy, nearly every physician in the city became a surgeon in the Confederate Army. The medical students joined as well, and this resulted in the closing of both schools by 1862. When the Union

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Army captured New Orleans in May of 1862, the forces occupied both schools, using the New Orleans College of Medicine as a primary school. With most physicians serving in the Confederate Army, every hospital except for Charity Hospital and Hotel Dieu closed, as did all the private sanitariums. To prevent federal occupation, Touro Infirmary ceased operation as a hospital and temporarily became a home for elderly Jewish residents. A year into the Civil War, the medical establishment had become radically altered.

In the Reconstruction years, the medical system in New Orleans underwent a significant transformation. For a brief period, the medical system became largely detached from its ties to slavery. Slave hospitals shut down. Funding from the slave-produced economy diminished and the usage of enslaved laborers in hospitals ceased. Care for enslaved patients paid for by enslavers continued over two more years, as the federal government permitted the continuation of slavery in Union-captured territory despite Lincoln’s Emancipation Proclamation until the ratification of the state's new constitution in September 1864. During this more than two-year period, Hotel Dieu

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175 In captured territories, the Union Army often occupied college campuses—including Louisiana State University—as their existing large buildings served well as troops barracks, headquarters, and hospitals.

176 More than half of the University of Louisiana Medical School's graduates from 1836-1862 served in the Civil War, all for the Confederacy. Most worked as medical officers; at least 170 medical officers were University of Louisiana graduates. At least 33 died during the war. "University of Louisiana Medical School Catalogue from 1834 to 1872," 1872, Stanford E. Chaille papers, LRCTU. Of the 16 medical colleges in the seceding states, only one remained open after 1861, the Medical College of Virginia in Richmond. Robert G. Slawson, "Medical Training in the United States Prior to the Civil War," *Journal of Evidence-Based Complementary & Alternative Medicine* 17, no. 1 (2017): 11-27.
continued to treat enslaved individuals brought in and paid for by slave owners until slavery's literal last days in Louisiana.\textsuperscript{177}

Thus, federal occupation did not completely end the medical system's ties to slavery, nor did it immediately lead to open access for African Americans to hospitals. While Hotel Dieu treated enslaved people brought in and paid for by enslavers through July 1864, the hospital did not admit its first non-enslaved African American until December 1865. African Americans would help force access to health care through large-scale volunteering to fight for the Union Army and through the arrival to New Orleans of thousands of formerly enslaved people seeking their freedom. In 1862, the Union army created the U.S. Colored Troops predecessor the Corps d' Afrique, composed of free men of color and formerly enslaved men, and the Corps d' Afrique Hospital in New Orleans. Although the army provided little funding to this hospital in comparison to hospitals for white troops, the space provided care for hundreds of Black troops during the war.\textsuperscript{178}

Originally intended to serve only the Black soldiers, the hospital began providing care for all African Americans in the area, particularly the thousands of African Americans who self-emancipated during the conflict and came to New Orleans. In the east and west, as the Union army advanced, formerly enslaved people crossed Union lines seeking freedom. In response, the army created refugee camps, known as "contraband camps," including one at Camp Parapet, originally built in 1861 by Confederate forces to defend New Orleans from Union assault. Residents of the camps

\begin{footnotesize}
\begin{itemize}
\item[\textsuperscript{177}] "Hotel Dieu Hospital Patient Registers 1858-1900," Hospital Records Collection, CANOPL.
\item[\textsuperscript{178}] The War Department, "Reports of the Extent and Nature of the Materials Available for the Preparation of a Medical and Surgical History of the Rebellion" (Philadelphia: J.B. Lippincott & Co., 1865).
\end{itemize}
\end{footnotesize}
were considered "contrabands of war," no longer enslaved, but required to work for wages as manual laborers, teamsters, and laundresses for the army. By the summer of 1862, more than ten thousand formerly enslaved individuals lived in and around New Orleans; two years later, the number exceeded 30,000 people. Many were homeless and living on the streets. Over six thousand lived in the refugee camps around the city, located at Fort Jackson, St. Phillip, and Parapet, among many camps established along the Mississippi River. Refugees in the contraband camps faced poor living conditions. The army constructed temporary housing—mostly tents or huts—but, as officer F.S. Nickerson detailed, "very few of any suitable materials has been provided of which to construct." Nickerson described the conditions of the existing structures as "brutish": "Nearly all of the huts are open and leaky—in capable of protecting either from rain or cold. Many of them are much more suitable for hog-pens than for human beings to inhabit." Conditions gradually improved, as the army constructed better shelters and commandeered buildings within the city to house people. Still, many suffered, and their conditions worsened because of discrimination. Blacks made up 25% of the city's population, and by the end of 1863, over 90% of relief—food and direct monetary payments—went to white families inside the city. Hundreds in the camps around New Orleans died of disease, with epidemics of cholera and smallpox. Non-epidemic diseases

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180 Blasingame, Black New Orleans, 51.
181 Blasingame, Black New Orleans, 52.
like dysentery and diarrhea proved even more rampant and equally deadly. The lack of food made people more susceptible to afflictions.  

Camp residents also faced constant threats of violence. Confederate guerillas regularly raided the refugee camps in Louisiana, capturing for enslavement or killing residents. Union troops established a garrison of one thousand soldiers at Brashear City, about seventy miles west of New Orleans, with a supply depot, hospital, and refugee camp. Confederate forces captured the garrison and slaughtered the African Americans living there. Reports from the period—difficult to verify—claimed Texas soldiers massacred as many as two thousand men, women, and children.  

Those who lived outside of the camp in the city—New Orleans's Black population more than doubled in the 1860s to 50,456 by 1870—also faced hunger, malnutrition, disease, and physical violence. Many arrived destitute, with no money, food, or place for shelter. Freedpeople settled in tenement buildings in the Central Business District; in flood-prone areas in the swampy back-of-the town areas; or along the industrializing riverfront, mostly all in poor-quality housing. Most African Americans struggled to find work, exacerbated by the postwar economic downturn. Many white employers refused to hire African Americans, and some unions refused to admit Black members. This discrimination forced African Americans to take positions as unskilled laborers and servants; in 1870, for example, while African American men made up only 23% of the

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182 For more on conditions in refugee camps, see Jim Downs, *Sick from Freedom* and Manning, *Troubled Refuge*.
city’s labor force, they made up 52% of unskilled laborer and 57% of servant positions. Many who worked as domestics lived in close proximity to white homes where they worked, with the white homes along the main avenues like St. Charles and Black homes on interior blocks. The collapse of the Freedman's Saving and Trust Company in 1874 wiped out the savings of many who were able to find jobs and save money.

Most of the refugees suffered from a lack of formal education. During occupation, the Freedmen's Bureau and the American Missionary Association established Black schools. In 1868, the state's new constitution forbid segregation in the Orleans Parish schools, although some schools resisted for several years; an estimated 500 to 1000 Black students attended school with white children annually from 1870-1874.

Compounding housing, education, and employment issues, Black New Orleanians faced open hostility, particularly from white European immigrants who viewed them as competition for jobs, and violence from whites. In addition to the Mechanics Institute Massacre of 1866 and the Battle of Liberty Place in 1874, whites committed everyday acts of threats and attacks. For example, in March 1867, General Samuel, in charge of the Freedmen's Bureau in Louisiana, reported that from July 5, 1865 to February 20, 1867, whites shot at, stabbed, or beat 210 freedmen and murdered at least 70 others statewide; this number did not include those wounded or killed in the Mechanics Institute Massacre.

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185 Blassingame, Black New Orleans, 61.
186 Campanella, Bienville’s Dilemma, 64.
188 Blassingame, Black New Orleans, 122.
189 Blassingame, Black New Orleans, 61.
Thomas stated that parish officials also underreported many acts of violence towards African Americans, and estimated that the number of murders of freedmen by whites was probably at least double the official statistic. Thomas noted that no white man was punished for any of the attacks or murders, with the coroners or juries acquitting most whites charged.  

The combination of these factors—poverty, violence, poor nutrition, inadequate housing, lack of education, and unemployment—resulted in high rates of disease and mortality. In the first half of the nineteenth century, free people of color had a longer life expectancy than whites, due to the high immigrant mortality rate caused primarily by yellow fever. In 1861, the first year of the Civil War, the Black mortality rate of 37.16 per 1,000 slightly exceeded the rate of 31.58 for whites. By 1864, the growing health disparities resulted in Black mortality rate of 81.75 per 1,000 compared to 42.14 per 1,000 whites.

Facing this mounting health crisis, the federal government made a fateful decision to address the health crisis that limited the push for equality in the medical system. Rather than force the existing hospitals—Charity and Hotel Dieu—to admit Black patients, the federal government created separate and federally-administered Black hospitals. All intended to be temporary, the Black hospitals were all plagued by underfunding, lack of supplies, and other problems. The first such space in New Orleans was the Corps d'Afrique Hospital, a 1,700-bed institution which primarily treated Black soldiers, but

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190 Samuel Thomas, "Miscellaneous Reports and Lists Relating to Murders and Outrages," March 9, 1867, Records of the Bureau of Refugees, Freedmen, and Abandoned Lands, National Archives and Records Administration (Hereafter referred to as NARA).
also began admitting Black civilians. A register from the hospital from Sept. 30, 1863-January 28, 1864 listed 108 patients labeled as "contrabands." Of these patients, 39 suffered from intermittent fever; 32 from diarrhea, 7 from scurvy; and 4 from smallpox, all common afflictions due to the poor living conditions in the refugee camps and in the city. Thirteen of these patients died in the hospital.  

Services expanded when the newly created Freedmen's Bureau took over the hospital in December 1865. Established by Congress as the Bureau of Refugees, Freedmen and Abandoned Lands in March 1865, the agency focused on several components in aiding recently emancipated individuals: education in the form of schools; distribution of clothing, food, and other supplies; securing labor contracts; settling freedpeople on confiscated and abandoned land; helping Black soldiers secure pay and benefits including pensions; protecting African Americans from violence; and providing legal representation. In June 1865, the head of the Freedmen's Bureau, Oliver O. Howard, created the agency's Medical Division, which established Freedmen's Hospitals throughout the South.

When the Freedmen's Bureau assumed control of the Corps d'Afrique Hospital in New Orleans in December 1865, the agency transferred all patients to the vacant Marine Hospital, which then became the city's Freedmen's Hospital. The hospital, which had cost half a million dollars during its construction from 1856-1858, had never been fully occupied prior to the Civil War due to continual problems, including the sinking of the building caused by its cast-iron framework. During the war, Confederate forces used it as

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a hospital and an arsenal. Union forces too used it as a hospital for white troops, until the
Freedmen's Bureau assumed control of the space. The building also contained the
Dependents Home Branch—for African Americans too ill or disabled to live on their
own—and an orphan asylum for Black refugee children.\textsuperscript{193}

The 600-bed Freedmen's Hospital in New Orleans was one of three hospitals
established by the Freedmen's Bureau in Louisiana in 1865 and 1866, with the other two
in St. Charles Parish and Shreveport, as well as smaller dispensaries in Gretna, Algiers,
Carrollton, St. John the Baptist, Gretna, Assumption, and two in New Orleans. The
Freedmen's Hospital in New Orleans treated thousands of Black patients during its four-
year existence. Freedmen's Hospital in New Orleans had the highest death rate, but this
also reflected the fact that the bureau usually sent those most ill to that hospital. From
January to November of 1866, the hospital provided care for 2,030 individuals, with 547
deaths, a 27\% mortality rate. An outbreak of cholera that year drove up the death rate—
the hospital treated 239 cases of cholera, with 141 fatalities.\textsuperscript{194} However, other ailments
remained the most significant killers. For example, during the summer of 1867,
physicians listed dysentery and diarrhea as the most common cause of death, followed by
phthisis (tuberculosis); pneumonia; smallpox; and cholera.\textsuperscript{195} In 1866, the bureau's

\textsuperscript{193} Joh Duffy, The Samaritans: A History of American Public Health (Urbana:
University of Illinois Press, 1990), 161.
\textsuperscript{194} "Report of the Operation of the Medical Department Bureau State of Louisiana
for the Year 1866," October 31, 1866, Records of the Bureau of Refugees, Freedmen, and
Abandoned Lands, NARA.
\textsuperscript{195} Abstracts of Interments at Freedmen's Cemetery, New Orleans, Louisiana
May 1867 - July 1867, Records of the Bureau of Refugees, Freedmen, and Abandoned
Lands, NARA.
hospitals and health stations statewide treated 5,106 African Americans, with 762 deaths statewide, for a 15% in-hospital mortality rate.\(^{196}\)

Health care for African Americans from the Freedmen's Bureau suffered in many ways. First, the bureau did not distribute enough rations to the Freedmen's Hospital. Second, army supply officers refused to turn over promised articles of clothing and supplies. Third, the bureau provided little care in the rural districts of Louisiana, refusing to treat Black laborers on former plantations, considering it impolite to place physicians on these fiefdoms; the plantation owners also promised to provide medical care for laborers, although few did.\(^{197}\)

Fourth, many of the bureau's administrators, agents, and doctors adhered to the same racist ideas as the proponents of slavery. In his 1866 annual report, Freedmen's Hospital head surgeon E.H. Harris noted that the number of treated cholera cases that year was "remarkable" in "view of the of the filthy conditions of the city & the general habits of the freedpeople as a class." Harris also wrote that African Americans were "naturally indifferent to the suffering of others." Thus, Harris, and many of the officials that worked for the bureau, continued to hold beliefs similar to those purported by Cartwright and others that African Americans were by nature unhygienic and unable to properly care for themselves.\(^{198}\)

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\(^{196}\) "Report of the Operation of the Medical Department Bureau State of Louisiana for the Year 1866," October 31, 1866, Records of the Bureau of Refugees, Freedmen, and Abandoned Lands, NARA.

\(^{197}\) For more on problems with Freedmen's Hospitals and the Medical Division, see Downs, *Sick from Freedom*.

\(^{198}\) Report of the Operation of the Medical Department Bureau State of Louisiana for the Year 1866," October 31, 1866, Records of the Bureau of Refugees, Freedmen, and Abandoned Lands, NARA.
Fifth, and perhaps most significantly, bureau and other federal officials did little to push local and state officials to aid freedpeople, including admittance to hospitals. Dr. E.H. Harris wrote in his 1866 report:

The civil authorities in this state do not seem inclined to take any care of sick & destitute refugees and freedmen, not do I believe they intend to do so…In this city the civil authorities made no provision whatever to relieve sick and destitute freedmen. They are not admitted to the Charity Hospital unless it be some exceptional cases of more than usual interest to the medical profession. The same feeling is exhibited throughout the state generally. Cases are sent to the Freedmen's Hospital in this city from all parts of the state, on the grounds they they are burdens to the Parish & authorities refuse to care for them and turn them over to the Bureau agents.199

Although they asked for local officials to admit freedpeople to public hospitals, they did nothing when institutions like Charity refused to comply. As noted by Harris, the bureau also permitted parishes statewide that had no hospital administered by the agency to send Black patients to the Freedmen's Hospital in New Orleans, rather than treat them in their local hospitals. This occurred even as the bureau began to close down their operations in the South; thus, bureau officials knew that African Americans would soon be largely shut out of health care in Louisiana.

This also occurred as freedpeople continued to face violence from whites. In New Orleans, this violence exploded in the form of the Mechanics Institute Massacre of 1866. That July, white supremacists attacked and murdered supporters of the constitutional convention marching in favor of African American suffrage. The perpetrators, many of them former Confederate soldiers and members of the New Orleans police force—as well as the city's mayor—killed as many as 200 African Americans. Only blocks away from

199 "Report of the Operation of the Medical Department Bureau State of Louisiana for the Year 1866," October 31, 1866, Records of the Bureau of Refugees, Freedmen, and Abandoned Lands, NARA.
the attack, Charity Hospital treated white victims, but refused to admit Black patients; the
Freedmen's Hospital, still located across the river in Algiers, treated the 119 African
American patients.\footnote{200 "New Orleans Riots," 39th Congress Report No. 216 February 11, 1867.}

Despite this event and other similar acts of violence, and the continued refusal of
local and state hospitals to admit Black patients, the Louisiana medical division of the
Freedmen's Bureau began shuttering operations in 1867, two years after opening. Many
hospitals lasted for only months. The department established temporary dispensaries in
1867 in Gretna, Assumption, the Second District of New Orleans, Monroe, New Iberia,
and Vidalia, primarily in response to outbreaks of epidemics of cholera, smallpox, and
yellow fever, and shut them down after the outbreaks subsided. As the hospital closed
these temporary dispensaries and the other full-scale hospitals—shuttering their hospital
in St. Charles Parish in January 1867 after less than a year of operation—the patient load
at the Freedmen's Hospital increased. In 1867, the institution treated 5,918 patients, with
468 deaths, an 8% mortality rate. Epidemics of cholera, smallpox, and yellow fever
accounted for 12% of cases and 27% of deaths, but most patients continued to be
admitted for problems like diarrhea, dysentery, tuberculosis, and pneumonia. The hospital
also treated 110 white refugees of war; it is not indicated in the records if white and
Black patients were treated in separate wards.\footnote{201 "Report of the Operation of the Medical Department Bureau State of Louisiana for the Year 1867," Records of the Bureau of Refugees, Freedmen, and Abandoned Lands, NARA.}

Although the hospital in New Orleans witnessed increased admissions, the bureau
attempted to reduce personnel and funding, which had already been low and had led to
ration and medicine shortages in 1866. The hospital's chief surgeon Charles Warren noted
in his 1867 report that the hospital "is conducted with a view to promote economy compatible with efficiency." One way the administrators attempted "economy" was reducing the number of nurses and having convalescents carry out their duties. The hospital's chief surgeon also had disabled and blind patients engage in manufacturing baskets, which the institution sold. The surgeon further believed that this work "would be of benefit to the dependents." This again reflected stereotyped views of African Americans that Freedmen's Bureau employees accepted. In this case, hospital administrators warned of freedmen as "lazy" and "malingers," and the danger of them becoming dependents. In his May 1868 report, he stated that "hospitals have a tendency to degenerate into almshouses," which he tried to prevent. In August 1868, he noted that he had orated "stringent and repeated instructions" to doctors to reduce the number of sick by only admitting the "deserving"—the "indigent sick"; treating most as outpatients; and discharging patients as quickly as possible. Warren, reflecting a larger view of the Freedmen's Bureau, viewed it as his role to teach the freedmen how to take care of themselves, which enslavement had left them unable to do. He wrote in his December 1868 report:

Freemen are beginning to see the merit of relying upon their own efforts for support in sickness as well as in health to learn that industry and thrift are the best preventative for want and suffering and only sure preservatives of manhood and independence.

Warren believed that labor on plantations would best serve formerly enslaved individuals. He argued that planters were mostly fulfilling their contracts by paying wages and

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providing medical care—negating the need for bureau doctors. He further posited that the work was instilling self-sufficiency.  

Warren's attitudes revealed one of the fundamental problems with the medical division, and the Freedmen's Bureau in general. At a time period when freedpeople most needed assistance, the agency provided inadequate and increasingly dwindling resources, and instead emphasized the need for Blacks to provide for themselves, even though few opportunities for self-sufficiency existed in the white supremacist South. Bureau officials and the Johnson Administration argued that securing employment would help prevent health problems, and thus Freedmen's Hospitals would not be needed as long-term solutions. As freedpeople struggled to find employment and housing, and suffered from severe health problems and epidemics, Congress increasingly cut funding to the bureau. This resulted in further shuttering of medical institutions in Louisiana and increased pressure on the Freedmen's Hospital in New Orleans. The Bureau closed the Shreveport Hospital in May 1868, and the hospital dispatched patients to New Orleans. By September 1868, only a medical dispensary and the hospital in New Orleans remained open for the whole state. The bureau shuttered the smallpox and cholera wards at Freedmen's Hospital and cut the physician staff to seven—down from a peak of fifteen—despite the number of patients climbing 45% from the previous year to 8,759.  

Even more consequentially, the Freedmen's Bureau did not mandate that public and private hospitals accept Black patients. Warren and other bureau officials repeatedly asked local officials to pledge to provide medical care for Black patients with little  

success. The bureau closed its dispensaries and hospitals with some municipal promises to offer treatment in their absence, but these appeared to have been empty words. For example, the bureau closed the Shreveport Hospital in May 1868 with local officials pledging to care for the freedmen. However, Warren wrote on September 30 of that year that "nothing had been done by authorities to care for the indigent sick." The following month he complained that he had repeatedly written to the mayor of New Orleans to pledge to treat patients "regardless of race or color," with no reply.\footnote{Report of Lucius H. Warren, Nov. 6, 1868, Records of the Bureau of Refugees, Freedmen, and Abandoned Lands, NARA.} Despite these failed assurances that Black patients would receive medical care in hospitals, the bureau slowly closed down the remaining hospital in New Orleans. Originally, the department intended to shutter the space by January 1, 1869, the official end date for the Freedmen's Bureau. However, the hospital remained open until June 1869—with one physician treating over 130 patients on expenditures of less than 45 cents per patient per day—because the local hospitals in New Orleans refused to accept the Black patients.\footnote{"History," Records of the New Orleans Field Offices, Bureau of Refugees, Freedmen, and Abandoned Lands, 1865-1869 (Washington: National Archives Trust Fund Board National Archives and Records Administration, 1987), 2.}

Ultimately, the Corps d'Afrique Hospital and its successor, the Freedmen's Hospital, were both successes and failures. While hampered by poor supplies, rations, underfunding, lack of personnel, overcrowding, and racist attitudes of some officials, these spaces presented the first true open access to hospitals for Black New Orleanians in the city's history. Their service from 1863-1869, as well as the desegregation of Charity Hospital from 1868-1877—discussed in the following section—represented an opportunity to end apartheid health care.
Ultimately, the work of the Freedmen's Hospital—and perhaps the very fact that it was a separate space for Black patients rather than mandating non-discrimination in all hospitals in the federally-occupied state—did not lead to a permanent change in health care in the city's other hospitals. Hotel Dieu provided extremely limited care for free people of color. After the abolition of slavery, the hospital, which had treated hundreds of enslaved people brought by slave owners, treated only thirteen individuals that hospital records identified as a free man or woman of color. The first patient, Josephine, was treated for burns from Dec. 14-15, 1865; the last, Ben Osetors, received care for seizures from May 30-June 8, 1869. After that date, every patient in the hospital's records is identified as white. Private hospitals in New Orleans would not admit a Black patient again until integration in the 1960s.208

Charity Hospital Under Occupation

In contrast, for a period lasting from 1868-1877, Charity Hospital was fully integrated, despite its refusal to do so during the early years of federal occupation. During the war, Charity declined sharply, as a naval blockade reduced the number of immigrants to the city. This population loss meant a loss in revenue because of the corresponding tax on passengers that helped fund the institution, as well as a loss in access to medicine, rations, and supplies. Charity also provided care for Confederate soldiers, with no compensation from the Confederate government, which further drained the hospital's scarce resources.209 With the city's capture and occupation, hospital leaders initially refused to treat federal soldiers. However, upon discovering that the hospital provided

209 "Charity Hospital Annual Report 1861," Charity Hospital Records RMTU.
care to Confederate soldiers, federal troops assumed control of the hospital, and triggered a forced removal of the board of administrators and the voluntary resignation of most of the hospital staff. Ernest Lewis, a twenty-one year old medical student, became the house surgeon despite not yet graduating. The hospital lost the revenue from renting out the Union Cotton Press, as the army used the building for housing of occupying troops. The number of patients served declined to a low of 4,857 in 1864. The federal government provided rations, medicine, and other supplies, but the hospital was severely underfunded. Administrators asked for at least $100,000 dollars in appropriations from the state legislature in 1864 for needed repairs to the building which they described as "falling into decay." 

Patient numbers began to increase after the war ended as the port slowly regained some of its prewar trade and immigration. With the closure of the Marine Hospital in 1869, the federal government temporarily awarded the contract for care of merchant seamen to Charity, providing over half of the hospital's budget in the 1870s. Still, the hospital continually struggled financially, as state aid proved inadequate and debts mounted. Administrators repeatedly cut expenditures, lowering the quality of care, and even had patients help with upkeep like painting and minor repairs. Annually, the hospital board asked the state for more aid, and to establish a state almshouse as they argued Charity had become the de facto facility for the poor not just for New Orleans and Louisiana, but for states throughout the region in the postwar period also.

However, Charity's most significant change during occupation was integration. In September 1868, the hospital board adopted a non-discrimination measure, resolving

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210 "Charity Hospital Annual Report 1864," Charity Hospital Records, RMTU.
"that in admitting sick persons to the benefits of this hospital no distinction be founded on race, color, or previous condition."\textsuperscript{211} This change in hospital policy primarily reflected the larger Reconstruction politics of occupied Louisiana. Despite federal occupation, many former Confederates regained political power in 1865, and the state legislature passed restrictive Black Codes, including legislation that barred African American from voting. These laws combined with white violence—including the 1866 New Orleans Massacre—helped maintain white supremacy in Louisiana. State leaders permitted Charity to continue to deny access to Black patients. However, Republicans in the state began gaining political power in the fall of 1866, aided by federal actions including the ratification of the Fourteenth Amendment in 1868 and the 1867 and 1868 Reconstruction Acts, which divided the South into military districts and placed greater federal control and military presence in the former Confederate states to protect Black male suffrage.

With these measures, Republicans elected H.C. Warmoth as governor in 1868 and gained control of the state legislature. In 1868, the Republican majority legislature ratified a new constitution which removed the Black Codes and enfranchised all men over the age of 21 residing in the state for a year, among numerous provisions. The 1868 constitution also guaranteed "public rights," which it detailed in Article 13:

\begin{quote}
All person shall enjoy equal rights and privileges upon any conveyance of a public character; and all places of business, or of public resort, or for which a license is required by either State, parish or municipal authority, shall be deemed places of a public character, and shall be open to the accommodation and patronages of all persons, without distinction or discrimination on account of race or color.\textsuperscript{212}
\end{quote}

\textsuperscript{211} "Charity Hospital Annual Report 1869," Charity Hospital Records, RMTU.

\textsuperscript{212} For more on Reconstruction politics in New Orleans, see Nystrom, \textit{New Orleans after the Civil War}. For more on the 1868 constitution, its context, connections to a transnational freedom struggle, and the violence that led its replacement, see Rebecca
With this radical change in the state constitution that included the concept of political rights and public rights, in 1868 the Republican-controlled state legislature ordered Charity hospital to implement a non-discrimination policy, over the objection of Democrat representatives. With the closing of the Freedmen's Hospitals in June 1869, the institution's remaining 400 Black patients were transferred to Charity. The number of Black patients from 1868-1876 at Charity Hospital is unknown, as the annual reports did not count patients by race. In 1877, when Charity again began segregating patients, the hospital had total admission of 1,039 Black patients, out of 6,695 total, for 1876. While admission numbers rose in the early to mid-1870s, administrators noted that the hospital had not witnessed an increase in Black patients; thus, it is likely that the 1877 figure of 1,039 closely matches the number of Black patients in the preceding years.213

In addition to admitting Black patients, in 1871 Charity Hospital also permitted the first Black physician as a member of the visiting surgical staff. Born in New Orleans in 1846, James T. Neman received his medical education in Canada, before establishing a practice in Chicago. Newman returned to the Crescent City to work in a hospital dispensary administered by the American Missionary Association.214 Newman performed surgeries on Black patients at Charity, and trained Black students of Straight University's short-lived medical program in teaching sessions in the surgical wards at Charity Hospital—this program will be detailed in a following section. Although only allowed to

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213 "Charity Hospital Annual Report 1877," Charity Hospital Records, RMTU.

214 Founded in 1846 as an abolitionist organization, the AMA created more than 500 southern schools and colleges during the Civil War and Reconstruction periods. For more on the AMA, see Joe M. Richardson, Christian Reconstruction: The American Missionary Association and Southern Blacks, 1861-1890 (Tuscaloosa: University of Alabama Press, 2009).
practice on Black patients, Newman and his medical students' presence in the hospital represented a significant break from the medical system of the past.

**The Postwar Health Care System**

This Reconstruction-era opening of health care for African Americans proved short-lived and only occurred at Charity Hospital. Despite federal occupation and the "public rights" provision of the 1868 state constitution, private hospitals continued to refuse to admit Black patients. As detailed earlier, the records of Hotel Dieu have no Black patients after 1869, and Touro Infirmary admitted no Black patients after reopening in 1869. The city’s other smaller private hospitals followed suit and denied admission to African Americans. Administrators chose to do so, even though many badly needed patient revenue. New Orleans's economic and financial systems in the postwar years nearly collapsed due to the end of slavery and trade in slave-produced goods. Unlike Chicago, New Orleans had not invested in railroads, and instead continued to believe that steamboat trade would remain dominant. With changing trade patterns, New Orleans's role as a commercial center declined. Similarly, manufacturing was underdeveloped. Finally, the state was hurt by the Depression of 1873. Due to these factors, New Orleans's economy suffered through economic depression until the late 1870s.\(^\text{215}\)

The abolition of slavery ended a significant source of income for many of the hospitals. The fact that most private hospitals did not reopen after the war, and the struggle of those that did, demonstrated the reliance on slavery and the slave-based

economy. Because enslaved people comprised more than half of the patient base, many hospitals simply could not survive the ending of slavery. Even the larger hospitals that treated high numbers of enslaved people—Hotel Dieu and Touro—struggled to overcome this funding loss. Like Charity Hospital, newly arrived immigrants—primarily single or widowed men with no family to provide care—made up the vast majority of patients in the postwar decades at Touro and Hotel Dieu, although different social strata used different hospitals. The indigent, working poor, and sailors made up a large percentage of patients at Charity, whereas middle-class workers—peddlers, clerks, bookkeepers, shoemakers—used Touro Infirmary and Hotel Dieu.\textsuperscript{216} With economic depression, many private practices and hospitals never reopened, and others took years to return. In 1866, only three private hospitals had returned to operation: Stone's Infirmary—however he (Mr. Stone) died in August 1867 and the institution closed; the Circus Street Infirmary, and the Luzenberg Hospital, which functioned primarily as the smallpox and isolation hospital.\textsuperscript{217}

As the overall economic situation slowly started to improve with increasing river and port trade due to physical improvements to channels and the Mississippi River, several other hospitals opened or reopened: the French Hospital (operated by the French Benevolent and Mutual Aid Society) in Treme in 1867; Nathan Bozeman's Surgical and Women's Hospital, started in 1860 as a "slave hospital" and reopened in 1869; and DePaul Hospital (operated by the Sisters of Charity of St. Vincent de Paul, who cared for patients suffering from mental illnesses at Charity Hospital starting in 1841), in 1863 in

\textsuperscript{216} "Record of Patients in the Touro Infirmary of New Orleans, 1869-1891", Hospital Records Collection, CANOPL.
\textsuperscript{217} Matas, History of Medicine in Louisiana, 520
uptown. All three hospitals chose not to admit Black patients. Most white physicians also refused to accept African Americans as patients at their private practices.

Even Creoles of color struggled to find private physicians, despite their higher socioeconomic conditions. Creoles of color and their descendants still lived predominantly in Treme and the Marigny. Many of this group maintained jobs in skilled labor, such as plasterers, masons, carpenters, and longshoremen. Some owned businesses like tailor and clothier shops, grocers, and cigar factors. Others continued in professional positions including as physicians. Some owned joint stock companies or worked as commission merchants. With higher incomes, they could afford to send their children to one of seven, private schools established in the 1860s and 1870s. Some wealthy Creoles of color could afford the services of private Black physicians, although only ten Black doctors practiced in the city in 1870, a severely limiting factor.²¹⁸

The dearth of Black physicians reflected continued denial of admission to Black students at the medical schools. Like the private hospitals, the system of medical education slowly recovered in the postwar period. Union troops occupied the campuses of both the University of Louisiana and the New Orleans School of Medicine until the end of the war. After forced exile due to his unwillingness to sign a loyalty oath to the Union, E.D. Fenner returned to New Orleans and worked for months to secure the school's return, and reopened it in November 1865. However, Fenner died in May 1866, and the college found difficulty in attracting students who could afford medical school;

the college closed in 1870. The University of Louisiana struggled as well to attract students when it reopened in 1866, with only 32 graduates that year; in comparison, one hundred and thirty-four had graduated in 1861. The numbers slowly increased, but were still at slightly more than half of the prewar peak by 1871 with 72 graduates that year. Despite financial precarity due to low enrollment, both colleges refused to admit Black students in explicit violation of the 1868 state constitution. Like the private hospitals, these institutions faced no punishment from state or federal officials.

Even at Charity, the only hospital open to African Americans, Black patients faced discrimination and exploitation. Members of the paramilitary, white supremacist organization the White League including D. Warren Brickell, Samuel Choppin, and Henry Dickson Bruns returned to their positions at Charity Hospital after the war. While the Republican-controlled legislature pushed for equality for African Americans and ordered non-discrimination at the hospital, the physicians and surgeons who worked at Charity actively fought against these same ideals. These individuals still viewed Black bodies as subjects for experimentation and dissection, and "anatomical material" for white medical students.

The hospital's head surgeon and chief administrator, Andrew Smyth, set the tone through his exploitation of African American patients. In 1864, chief surgeon Smyth operated on William Banks to remove a tumor on his neck. A decade later, Banks returned with another tumor on his neck. Smyth did not operate this time, as he felt Banks's condition was terminal. When Banks died, Smyth wanted to dissect Banks's corpse, and keep the upper part of the body in his anatomical collection as the operation

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219 Fenner, "Transactions."
in 1864 on the pulsating tumor was the first such surgery of its kind on record. However, Banks belonged to a fraternal organization that demanded the hospital turn over his body for burial in accordance with Banks's wishes. Smyth ordered his assistant Edmond Souchon, to dissect the body and sneak out the desired section while Smyth, argued with the fraternal organization in the waiting room as a distraction. Years later, Souchon recalled with pride the incident describing it as a "living legend throughout the medical world" and spoke amusingly of the appalled looks on Banks's friends' faces upon finally seeing his body: "But judge of their shock and horror when they saw all that was left of their saint, two legs with the viscera and a left arm without being able to find where the balance had gone." Souchon gleefully told friends that Banks's compatriots never found out what happened to the rest of his body.220

These same men also taught at the medical schools. Brickell led the New Orleans School of Medicine after Fenner's death—and continued to teach Obstetrics and Diseases of Women; fellow White League leaders Choppin and Bruns served as faculty members. After the school closed in 1870, Brickell founded and headed the short-lived Charity Hospital Medical College from 1874 until it too closed in 1877. At the University of Louisiana, under the supervision of Dean Tobias G. Richardson, the former head surgeon of the Confederate Army, the faculty included Stanford Chaille, leader of the New Orleans White League. Both schools continued to receive Black cadavers for dissection and anatomy lessons from Charity Hospital; in 1869, the year that Charity began admitting free people of color, the New Orleans School of Medicine (NOSM)'s annual report noted that the "anatomical material is always abundant." At the New Orleans

School of Medicine, students also continued to utilize Fenner's anatomical museum, comprised primarily of body parts of enslaved people donated by white physicians. In the late nineteenth century Edmond Souchon started his own such museum at the University of Louisiana, one that reached national renown.\textsuperscript{221}

The University’s medical class of 1871 graduated 64 men. Of those, twenty-two had been too young to serve in the war. Of the 42 old enough to serve, thirty-nine were veterans of the Confederate Army. While smaller in size than in the prewar period, the University of Louisiana in particular dominated the medical profession in New Orleans. By 1872, graduates of the school comprised two-thirds of all physicians in the city. Graduates also worked as physicians in other parts of Louisiana and in other southern states, and served as sheriffs and state representatives and senators, demonstrating the school's prominence. Instilled with the lessons of scientific racism that predominated the pre-war period, the next generation of physicians in New Orleans—many of whom were participants in the White League and other white paramilitary organizations—would continue to use their positions as doctors to uphold white supremacy.\textsuperscript{222}

**Black Medical Schools and Physicians**

Excluded from medical schools in New Orleans—in violation of the 1868 state constitution—and most medical schools nationwide, African Americans found some opportunities for higher education with a series of Black colleges founded by organizations like the AMA and Freedmen's Bureau, starting with Howard University in 1868. Several of these colleges included medical programs. In New Orleans, two schools

\textsuperscript{221} "Circular of the New Orleans School of Medicine, Course of Lectures for 1868-69," Stanford E. Chaille Papers, LRCTU.

\textsuperscript{222} "Medical School Catalogue," Stanford E. Chaille papers, LRCTU.
attempted to initiate medical programs as well. Black and white civic and religious
leaders founded three Black institutions of higher education, creating Straight University
in 1868, Leland University in 1870, and New Orleans University in 1873. Albeit briefly,
both Straight University and New Orleans University established medical programs, the
third and seventh Black medical colleges in the country.\textsuperscript{223}

Funded by the American Missionary Association and the Freedmen's Bureau,
Straight University included medicine as one of eight initial programs. In January 1870,
the legislature appropriated $35,000 to start and house the medical department. White
legislators may have been motivated by a desire to circumvent Article 135 of the 1868
state constitution which forbade the establishment of colleges "exclusively for any race."
Fearing a push for the integration of Louisiana State College and the University of
Louisiana, politicians supported state funding for Straight University to address Black
higher education without integrating white institutions. However, Governor Henry Clay
Warmouth vetoed the bill. While the school awaited the outcome of a lawsuit to receive
the funding, Straight established a medical program under Dr. James T. Newman. At the
time, Newman was running the AMA's Hathaway Home for the Poor and Friendless
which provided free care for indigent white, Black, and foreign individuals from 1870-
1871.\textsuperscript{224} As Straight waited to see what would happen with state funding, Newman began
preparing the medical program and officials hoped to buy a lot for the medical building
near Charity Hospital. The Louisiana Supreme Court ruled against Straight and upheld
the governor's veto, stating that as a private institution it was ineligible to receive state
funding. Nevertheless, when the state colleges continued to refuse integration in violation

\textsuperscript{223} Savitt, "Straight University Medical Department," 177.
\textsuperscript{224} Richardson, \textit{Christian Reconstruction}, 66.
of Article 135, the legislature awarded limited funding for Straight, which was open to both Black and white applicants, although not enough to fully support the medical program.\textsuperscript{225}

Undeterred, Newman pressed for the opening of the medical program, which finally occurred in 1873 with ten white and Black male students. Newman served as the only instructor, and trained students in the medical and surgical wards at Charity Hospital, where he had attending privileges. The opening of the program, the Deep South's first medical program for Black students, was a notable achievement, and again could have led to significant changes in the medical system. However, foreshadowing many of the limitations imposed by the racist hierarchy and the city's power structure, the medical program faced insurmountable obstacles. The state's meager allocation of funding for Straight only provided $1000 to establish the medical program, far too little an amount. As a result, Newman was unable to hire any other instructors, and Newman paid for all the students' educational material out of his own salary.

Additionally, Newman faced institutional opposition within the school and the AMA. Anticipating twentieth century debates about the creation of separate Black medical institutions versus the push to integrate, Straight University President Samuel S. Ashley and other board members openly opposed the creation of the Black medical program. They favored a push to integrate the LSU and the University of Louisiana's medical programs. Facing an economic recession in 1873 and mounting costs for educational programs throughout the school, the board refused to grant Newman additional funding to purchase a separate medical building—the medical program

\textsuperscript{225} Savitt, "Straight University Medical Department," 185.
operated out of the school's main building on North Esplanade and North Derbigny streets—but approved his plan to raise money to purchase a lot on Common and Villere streets. Told not to solicit religious groups, Newman instead approached sympathetic physicians for financial support. However, a group of white doctors led by D. Warren Brickell bought Newman's desired lot and there started the Charity Hospital Medical School. Newman then proposed purchasing a hospital building on the corners of Claiborne and Canal, one block from Charity Hospital. Again, the AMA allocated no funding but approved Newman's plan to fundraise $5000. However, Newman failed to secure the money, as few Black doctors practiced in the city, and white doctors refused to contribute. In 1874, Straight University discontinued its medical classes. A second medical college started as part of founding of New Orleans University in 1873, an institution funded by the Methodist Episcopal Church (MEC). School leaders envisioned a large medical college that would attract Black students from throughout the region. However, similar to Straight University, the program sputtered at first. Classes did not begin until 1878, with eight students and five faculty, including J. T. Newman, who served as dean of the faculty. Akin to Straight, the college discontinued medical classes after the first year due to financial difficulties.

The limitations, particularly financial, imposed by the existing power structure that derailed both attempts at establishing a Black medical school and permitted the illegal exclusion of Black students at the University of Louisiana severely limited the Black medical system in New Orleans. Some private Black physicians practiced in New Orleans.

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226 Savitt, "Straight University Medical Department," 185.
227 "The History of Flint Goodridge Hospital," 5 Marcus Christian Collection, LCUNO.
Orleans in the postwar years, and played significant roles in the Black community. Louis Charles Roudanez was the most prominent example. In addition to his practice, which he maintained until his death in 1890, Roudanez was a leading advocate of Black equality. Roudanez cofounded and personally financed *L'Union* (1862-1864), the first Black newspaper in the South, and in 1864 started the *New Orleans Tribune* (1864-1870), the South's first Black daily newspaper. Although criticized by some African Americans as elitist and representing the views of the wealthier Afro-Creole elite, the publication identified itself as the "organ of the oppressed" and the "organ of all colored people."

White supremacists also attacked the newspaper, perhaps the most radical in the country, as it championed abolition during the Civil War, African American enfranchisement after the conflict, wages for formerly enslaved African Americans, integrated schools, and the civil rights codified in the state's 1868 constitution. Two of his sons became physicians, and a third became a dentist.228

Like Roudanez, Eugene Dubuclet received his medical education and hospital training in Paris and practiced in New Orleans. His grandfather Antoine Dubuclet Sr., a free man of color, owned 22 slaves and partially owned a plantation in Iberville Parish. Through marriage, his father Antione Dubuclet Jr. obtained more land and more than one hundred enslaved people; by 1860, he was the wealthiest and largest slave owner among free people of color in the state. A prominent Black member of the Republican Party after the Civil War, he served as Louisiana's Secretary of Treasury from 1868-1878. Antoine sent all twelve of his children to France for education. Eugene operated a practice out of

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228 "The History of Flint Goodridge Hospital," 3, Marcus Christian Collection, LCUNO. Roudanez, "Grappling with the Memory of New Orleans."
his residence—which he shared with his father while the latter served as the State Treasurer—at 25 Robertson Street.\textsuperscript{229}

Roudanez and Dubuclet were outliers. Few African Americans had the resources to afford medical education in Europe, Canada, or the few northern schools that admitted Black students. The number of Black physicians, ten in 1870 and thirteen in 1880 in New Orleans or Louisiana, would not significantly improve until New Orleans University finally succeeded in opening a medical college in 1889, and administered a new hospital—what later became Flint Goodridge Hospital—starting in 1896. In the interim, some affluent Creoles relied on health care provided by fraternal organizations. In the late nineteenth century, a number of proto life and health insurance companies formed. For example, the Les Juenes Amis, founded in 1867, paid death benefits of $100 dollars, access to a physician to visit and provide pharmaceutical drugs for sick members, and weekly cash relief of $3 if they missed employment due to illness. The society hired three physicians and a pharmacist annually, the society paid the doctors a portion of $60 based on how many members they treated. To join the exclusive organization, a current member had to vouch for an applicant, and all the members had to vote on admission. Members paid one dollar a month in fees, and had to obtain a health certificate from a society physician before admission. A society physician had to also confer a certificate of illness for a member to receive medical care and sick benefits.\textsuperscript{230} La Concorde provided


\textsuperscript{230} Constitution and By-Laws of Les Jeunes Amis Organized Aug. 1, 1867, Incorporated March 2, 1875," Charles Rouseve Papers, LRCTU.
the same benefits for its members, including care by a society physician. Similarly, the Young Female Benevolent Association provided members—that paid 50 cents per month—sick benefits of two to four dollars per week and one dollar for doctor's visits, in addition to 50 dollars in death benefits.\textsuperscript{231} Wealthy African Americans, their benevolent associations, and Black churches also supported charity organizations, orphanages, and nursing homes for impoverished Black residents.\textsuperscript{232}

Most African Americans in New Orleans were shut out of the health care system with the closing of the Freedmen's Hospital in 1869. Their only option was Charity Hospital, which struggled in the 1870s to remain open due to lack of funding, and was staffed by physicians that openly advocated for white supremacy. By the end of

\textsuperscript{231} Blassingame, \textit{Black New Orleans}, 168.  
Reconstruction in 1877, African Americans made up 15.5% of the hospital's patients. African Americans were underrepresented at the hospital, as they made up 26.7% of the population; white foreign-born immigrants were overrepresented, as they made up 18.2% of the city's population, but 51.8% of patients. At the hospital, African Americans had a mortality rate of 22.8 percent, more than double the white rate of 11.3 percent. One factor was the disproportionately high numbers of respiratory problems like tuberculosis, pleurisy, bronchitis, and pneumonia, which were all symptomatic of poor housing conditions and nutrition. Strikingly, even at Charity, the hospital used by whites with the most negative social determinants of health—predominantly impoverished immigrants forced to live in low-quality housing, among other factors—African Americans still fared significantly worse, revealing the sharp racial disparity in health care.233

Rise of the Redeemers and the Institutionalization of Jim Crow Health Care

In the 1870s, the power of the Republicans waned and an already precarious situation for Black residents declined even further. Although a Republican, Governor Henry Warmoth backed away from his initial support for Black equality to secure more white electoral support. This move included his vetoing of legislation that would have enforced the protection of "public rights" by fining owners of public accommodation—which would have included hospitals—for discrimination or denial of admittance to African Americans. In 1872, Democrats disputed the election results that awarded the governorship to Republican William Pitt Kellogg, which led to armed conflict. In what become known as the Battle of Liberty Place, over five thousand members of the White League attacked the Metropolitan Police and deposed Governor Kellogg. Drs. Beard,

233 "Charity Hospital Annual Report 1877," Charity Hospital Records, RMTU.
Brickell, Bruns, and Choppin helped lead the organization; Bruns and Beard spoke at the White League rally on September 14th 1874 that immediately preceded the assault which resulted in the death of sixteen members of the White League, thirteen policemen, and six bystanders. President Grant's deployed federal troops who returned Kellogg to power after three days, but this event helped lead to the return to power of the Democrats, who elected former Confederate general Francis T. Nicholls as governor in another contested election in 1876, and effectively ended Reconstruction in the South.235

Under Democrat rule, local and state leaders began institutionalizing apartheid health care. When Nicholls assumed the governorship, he appointed Dr. Samuel Choppin, one of the organizers of the 1874 Battle of Liberty Place, as President of the Board of Health. The new state legislature approved funding for the Nicholls Home for Soldiers, which provided medical care for Confederate veterans; the founders of the home named it after the governor, a former Confederate general and the leading advocate of the institute's fundraising drive. Also in 1877, physicians formed the Louisiana and Orleans Parish Medical Societies (OPMS), headed by prominent members of the White League, including Choppin, Brickell, Bruns, and Beard. The OPMS proudly embraced their members' roles in the Battle of Liberty Place and other efforts to end Reconstruction,


with founders writing that "white patriots" created the OPMS as part of the "offspring of the hard-won liberty gained" against "scalawags and free negro slaves."

The OPMS instituted a whites-only membership clause. The OPMS also mandated that all hospitals in New Orleans only hire OPMS members, ensuring that no hospitals would integrate their staff until the OPMS did so—which did not occur until 1965. Local physicians furthermore succeeded in electing Dr. Tobias G. Richardson, former head surgeon of the Confederate Army and the Dean of the Louisiana College of Medicine, as president of the American Medical Association.\(^{236}\) Additionally, all private hospitals pledged to continue to deny admission to Black patients. Only Charity Hospital and the Marine Hospital admitted Black patients.\(^{237}\) However, the Marine Hospital only admitted dues-paying merchant seamen, a small portion of the city's Black population.\(^{238}\)

Outside of the merchant seamen, Black New Orleanians could only use Charity Hospital. However, Charity also embraced Jim Crow in the period. In violation of the 1868 constitution, Charity began segregating patients by race in 1877 and started treating African Americans in a separate ward in 1881; the new 1879 state constitution endorsed

\(^{236}\) Stanford Chaille, "Orleans Parish Medical Society History," 787, Stanford E. Chaille Papers, LRCTU.

\(^{237}\) It is unclear from the available historical record if Charity or Touro treated Black merchant seamen when they held the Marine Hospital contract from 1869-1885.

\(^{238}\) African Americans made up a sizeable portion of patients, comprising, for example, 45% of the hospital's 604 patients in 1890. Over 16% of patients came from Louisiana, and 84% of this group were African American. However, records do not specific residence, making it impossible to know how many Black New Orleanians the hospital treated; if all the Black Louisianans resided in New Orleans, the total in 1890 would have been eighty-one. It is unknown if the hospital treated Black patients in a separate space or building from white patients "Marine Hospital Records, 1890," LRCTU.
the practice. In 1877, the hospital fired James T. Newman, the hospital's only Black doctor who had served as a visiting surgeon since 1872.\textsuperscript{239}

However, little else changed for the health care system in New Orleans. Private hospitals and physicians continued to deny admission to African Americans. The Supreme Court endorsed segregation, first with the \textit{Civil Rights cases} (1883) which allowed states to permit discrimination in private establishments like private hospitals, and then with \textit{Plessy v. Ferguson} (1896), which legalized the segregation Charity had been carrying out for nearly two decades. With the University of Louisiana's official transition to Tulane University in 1884, the school adopted a whites-only clause, but it had refused to admit Black students since its opening in 1834. The school continued to receive "anatomical material" from Charity, primarily the cadavers of African Americans. Like E.D. Fenner at the New Orleans College of Medicine, Edmond Souchon, who served as a professor of anatomy for decades at the University of Louisiana, created a museum of anatomy, filled primarily with specimens from Black bodies. Souchon developed a national reputation for his museum, with other medical schools throughout the country asking for his consultation in establishing their own anatomical museums. In 1909, the \textit{New York Medical Journal} described Souchon's collection as "the finest room of its kind in this country or abroad." Medical groups across the country borrowed Souchon's collection for display at their medical school or conference for medical professionals, the Louisiana Board of Health utilized it in the 1910's as part of a traveling "Health Exhibit Train" that toured the state.\textsuperscript{240}

\textsuperscript{239} "Charity Hospital Annual Report 1878, 1881," LRCTU.  
\textsuperscript{240} Kenny, "Specimens," 173.
Beyond access to health care, Black residents continued to suffer from health disparity due a number of factors, including educational inequality in the underfunded and decaying buildings that served as Black schools.²⁴¹ African Americans continued to live in low-quality, overcrowded, and flood-prone housing that perpetuated high rates of tuberculosis, mosquito-borne afflictions like yellow fever and malaria, and other health problems. Everyday discrimination, intimidation, threats, and violence continued, and, in some ways intensified. From 1882-1936, whites lynched at least 333 African Americans in Louisiana, including at least fourteen in the New Orleans area.²⁴² In July 1900, Robert Charles shot a police officer who harassed and assaulted him. In retaliation for the shooting, mobs of thousands of white New Orleanians burned Black schools and businesses. They pulled African American riders off the streetcars and shot them and beat Black residents in the streets and in their homes. Whites murdered at least twenty Black residents; the city later arrested nine whites, but never tried or convicted anyone.²⁴³

New city and state laws intensified the restrictions, including the 1890 segregation of baseball games and boxing matches in 1892 in New Orleans; the 1892 state

²⁴¹ With the violence of 1874, the school system had largely re-segregated, a move retroactively permitted by the 1879 state constitution and mandated by the 1898 state constitution.


²⁴³ For more, see Ida B. Wells-Barnett, Mob Rule in New Orleans: Robert Charles and His Fight to Death, the Story of His Life, Burning Human Beings Alive, Other Lynching Statistics (Chicago, 1900). Hair, Carnival of Fury.
segregation of railroads; disenfranchisement in 1898 through new constitution's
requirements of a literacy test, poll tax, and a grandfather clause; the 1902 segregation of
New Orleans streetcars; and the 1908 state ban on cohabitation. While strict enforcement
of the segregation of public venues like bars, restaurants, and music venues did not occur
until the period during and after World War I, the late nineteenth century nonetheless
witnessed the further decline of Black rights in New Orleans.244

Racial health disparity accompanied the growing push for a culture of
segregation. In 1880, African Americans citywide suffered from a mortality rate of 36.6
per 1,000, compared to a rate of 24.41 for whites.245 This marked a significant change
from the first half of the nineteenth century, when free people of color in New Orleans
had a longer life expectancy than whites. Tuberculosis remained the largest health
problem. From 1877 to 1880, an average of 362 Black residents died from the disease,
accounting for 16.4% of Black deaths. While more whites died from the disease, an
average of 502 per year in that same period, tuberculosis disproportionately killed
African Americans, who made up 28% of the population but 42% of tuberculosis deaths.
Additionally, tuberculosis only accounted for 7.2% of white deaths, with yellow fever
still the largest single cause of death for whites. African Americans had an infant
mortality rate of 450 per 1,000 in 1880, and those who survived the first year could
expect to live to an average of 36 years compared to 46 for whites. Thus, Black residents,
who for half a century before the Civil War had a longer life expectancy than whites, now
on average died a decade earlier than whites. The fact that many of the city's Black
residents were formerly enslaved, with the lasting medical problems from years of abuse

244 Devore, Defying Jim Crow.
and medical neglect—their own personal "slave health deficits"—partially accounted for these figures, compounded by the problems and medical neglect they encountered in New Orleans after the end of slavery. While medical advances would lower the white mortality rate in the following decades, accompanied by a decline in the immigrant population more susceptible to yellow fever, the Black mortality rate increased as Jim Crow intensified, reaching a rate of double that of whites by the end of the century.\footnote{Blassingame, \textit{Black New Orleans}, 242.}

The decisions over health care made in the 1860s and 1870s directly resulted in this racial health disparity. The federal government's choice to operate a separate Freedmen's Hospital for Black New Orleanians, rather than enforcing integration at the city's hospitals; and the decisions of individual white doctors, hospitals, and medical to not admit Black patients, students, and doctors, paved the way for the institutionalization of Jim Crow health care after the end of Reconstruction. In the Jim Crow period, racial health disparity continued as the apartheid health care system expanded. However, two affiliated institutions, the Flint Medical School and Flint Goodridge Hospital, would make remarkable strides in addressing Black health problems and the lack of Black physicians.

**Flint Medical College and Flint Goodridge Hospital**

In April 1897, 68 candidates took their Louisiana State Board of Medical Examiners examination to become state-licensed physicians. In their report on the candidates' tests, the board noted of one candidate: "The colored woman passed an exceptionally good examination and the Board made special mention of her case." The board's citation applied to Emma Wakefield-Paillet. Born in Iberia Parish to a father who
served as a state senator during Reconstruction, Wakefield-Paillet attended prep school in New Orleans, Straight University, and medical school at New Orleans University. One of the first of the three women admitted to the school's nascent medical program, Wakefield-Paillet became the first Black woman in the state to earn a medical degree in 1897 and the first Black woman with a medical practice in New Orleans.\footnote{Phoebe Hayes, "Emma Wakefield-Paillet, MD," accessed January 11, 2020, \url{https://64parishes.org/emma-wakefield-paillet-md}.}

Wakefield-Paillet matriculated as part of the fifth class of the New Orleans Medical College. While the two earlier efforts at a Black medical program in New Orleans proved unsuccessful in the 1870s, a third attempt finally succeeded. In 1889, under the auspices of the Methodist Episcopal Church, New Orleans University re-opened its medical program as the New Orleans Medical College, again under the leadership of J.T. Newman. School leaders imagined New Orleans not just as the site for a new medical college—the only one for hundreds of miles—but as a leading medical hub for African Americans. Administrators hoped to raise $200,000 for a new medical college building; $75,000 in endowments; $10,000 for endowed professorships; and $25,000 for an endowed deanship. Although never able to meet these lofty goals, Bishop Willard Francis Mallalieu successfully lobbied MEC parishioner John D. Flint, a cotton manufacturer in New Orleans, to fund the purchase of a lot and three-story building on Canal and South Robertson Streets, plus an endowment of $10,000. The college used the first floor for lectures; the second for clinic rooms and operating rooms; and the third for laboratories. The school graduated its first class in 1892 and subsequently lengthened the
program from three years to four years.\textsuperscript{248} The students of the school—renamed Flint Medical College in 1901—initially could gain no experience working in a hospital as all hospitals in the city barred Black physicians. The African American community also needed a Black hospital, particularly for those ineligible for care at Charity Hospital; the hospital had income restrictions, although critics charged for decades that the hospital only laxly enforced the policy.

In 1894, a New Orleans chapter of the Phyllis Wheatley Club formed with the intention to create a Black hospital for those patients unable to use Charity. Black women's clubs originated in the late nineteenth century as benevolent organizations. During the Progressive Era, Black women's clubs like Phyllis Wheatley clubs focused on social reform issues including improving Black public health. These clubs—composed primarily of upper-income members—carried out neighborhood cleanups, health education campaigns, and started Black hospitals and nursing schools, including New Orleans's Phyllis Wheatley Sanitarium and Training Hospital for Nurses.\textsuperscript{249}

The New Orleans Medical College initially allowed the club to use one room with beds for seven patients in the medical program's building, starting in 1896. The club also

\textsuperscript{248} "The History of Flint Goodridge Hospital," 5, Marcus Christian Collection, LCUNO.
started a training program for nurses and provided an opportunity for medical students to gain practice on patients in a hospital setting. Due to financial problems, the club was unable to maintain the hospital and nursing program after the first year. The New Orleans Medical College took over the sanitarium and the nursing program. The two-year nursing program offered full-time students free tuition and board—students only had to pay for books—in exchange for serving as nurses at the hospital; non-resident, part-time students took three hours of class weekly and paid three dollars a month, which could also be reduced in exchange for nursing work at the hospital. Students from throughout the country and abroad attended the program, the only such program for African Americans in Louisiana or the three adjoining states.250

As he did with John Flint, Bishop Mallalieu successfully lobbied Mrs. Caroline Mudge of Boston—widow of Methodist minister Rev. Z. Mudge—to pledge several thousand dollars to buy land to establish a separate hospital in a pre-existing two-story frame building purchased in 1901. Mudge also gave a $25,000 endowment in the form of cotton mill stocks to support the new hospital. The school named the new sixteen-bed hospital Sarah Goodridge Hospital in honor of Mudge's mother.251

The opening of Sarah Goodridge—later renamed Flint Goodridge—Hospital, following the establishment of the medical school, marked a significant achievement for Black health care in New Orleans. African American students from throughout the region could now become nurses and doctors. African American patients—both paying, and indigent, as the hospital offered free care for low-income resident—could now access a

250 "The History of Flint Goodridge Hospital," 31, Marcus Christian Collection, LCUNO.
251 "The History of Flint Goodridge Hospital," 24, Marcus Christian Collection, LCUNO.
hospital, the only hospital in the Deep South to have Black doctors. The medical school and the hospital were also the region's only truly integrated institutions. The medical school admitted both Black and white students, and the hospital treated Black and white patients—not just from New Orleans, but from throughout the country and as far away as Switzerland, with many traveling to the hospital to use its services—under the care of both Black and white physicians; the hospital employed no full-time physicians and instead all doctors with private practices could treat patients as visiting staff. While dwarfed in size by the larger Tulane University medical school, Charity Hospital, and nearly every all-white private hospital, Flint Medical School helped swell the ranks of the area's Black medical profession and produce a new generation of Black leaders, and Sarah Goodridge Hospital treated hundreds of Black patients annually. By the turn of the century, New Orleans had become one of the country's leading Black medical centers. New Orleans contained one of the five Black medical colleges, and was one of only four cities in the country with a Black hospital, a Black medical college, and a Black nurse training program—Washington, Nashville, Raleigh, and Louisville were the others. While five other cities in the Deep South—Atlanta, Charleston, Montgomery, Savannah, and Tuskegee—had Black hospitals, the Flint Medical College and nurse training program in New Orleans set the Crescent City as the region's most significant city for the Black medical profession. However, in the early twentieth century, white leaders would push for the removal of Flint Medical School and Flint Goodridge Hospital in an effort to make the medical district a white space, an effort examined in chapter four.

252 "The History of Flint Goodridge Hospital," 42, Marcus Christian Collection, LCUNO.
CHAPTER 4: A WHITE MEDICAL DISTRICT, 1900-1940

Introduction

In 1925, Dr. James T. Newman was 76 years old and writing his memoirs, deemed by the *Louisiana Weekly* as a "very valuable addition to medical information." Seemingly, few men could have been better qualified to write such a work. The *Weekly* called Newman "the Dean of Negro Physicians." The *Times Picayune* labeled him as one of "the best known among the negro race in the country." For fifty years, Newman had been involved in nearly every important venture in Black health care in New Orleans. He had been a renowned surgeon, the dean of the city's first Black medical school, a professor for over 25 years, the director of the state's first two programs for Black nurses, a mentor for multiple generations of Black physicians, the first Black doctor at Charity Hospital, the first Black member of the New Orleans Board of Health, the head of surgery at the city's first Black hospital, and the chief of his own hospital. During the 1878 yellow fever epidemic, which killed over 4,000 residents, Newman had been helped lead the response by the Howard Association and personally treated 1,134 patients, with an astoundingly low 19 deaths. In 1902, the federal government appointed Newman to the U.S. Board of Pension Examiners. In 1914, he had served as the Chairman of the Colored Health Division for the response to Bubonic Plague. He was also a much-requested orator and civic leader, heading fundraising drives for Black institutions like the city's first Black YMCA.253

Yet, despite his feats, no figure better represented the limitations faced by the Black medical profession than Newman. The white-only University of Louisiana had

refused admission to Newman, a native son of the Crescent City, forcing him to study
medicine in Canada and initially start a practice in Chicago. Brought back to New
Orleans to run a medical dispensary, Newman had led both Straight University and New
Orleans University's initial efforts, doomed by the state legislature's illegal refusal to
provide funding. He had been the only Black physician at Charity Hospital from 1871-
1877, and was dismissed when the hospital segregated. In 1878, the city removed him
from the Board of Health. He had served as a professor of surgery at Flint Medical
College before the Flexner Report shut it down in 1911—detailed in this chapter.
With the closing of the medical school, Newman concentrated on running his own
hospital, the Provident Sanitarium and Nurse Training School. Newman started the
institution with support from the First District Baptist Association. Opened several blocks
from Flint Goodridge on S. Howard Ave. in the heart of the medical district, the hospital
offered several wards for patients—both Black and white. Under the auspices of a board
of directors with Bishop J.L. Burrell as president, Newman served as the chief surgeon
and head of the nurse training program, with two graduates of Flint Medical College—I.J.
King and Francis Nelson, both natives of New Orleans—as assistant surgeons and
instructors for the program. Although the hospital received support from the Baptist
Association and Black donors, like Flint Goodridge, it struggled financially. Through the
lobbying of Newman and the Board of Directors, the hospital secured an annual
allocation from the City Council. However, the council only gave $200; in comparison,
they awarded $2,000 and $2,500 respectively to the similar-sized New Orleans
Dispensary and the Eye, Ear, Nose, and Throat Hospital, and over $10,000 to the Touro Infirmary.²⁵⁴

In 1916, the hospital attempted to move to a new, significantly larger location on Third Street in Central City. Under the city ordinance, the hospital had to secure permission from the city council, which granted the request that October. However, in January 1917, a group of white leaders and residents, described by the Times Picayune as "bitterly opposed," came to the City Council meeting to protest their decision. Benjamin School Principal Ellen Murphy spoke on "behalf of the school children." The president of the Playgrounds Commission," Olive Stallings, spoke on "behalf of the children of Taylors Playground." The newspaper noted the women "based their objections upon the white children having to pass the sanitarium, and upon the possibility of the sanitarium leading to trouble between the races." Both women suggested placing the hospital in "more of a negro neighborhood," with Murphy arguing for a location in the area bounded by Freret, South Rampart, Toledano, and Washington streets, and Stallings pushing for a site opposite the Thomy Lafon playground, both further in to Central City. State Senator Stafford and Assessor James Mallow, spoke on "behalf of their constituents of the Eleventh Ward," who believed the "institution would depress property values." Others spoke to oppose the building "because it was a negro institution and others solely because it was a hospital."²⁵⁵

Attorney Richard B. Montgomery and U.S. customs inspector Walter L. Cohen represented Newman and the hospital at the meeting. They presented a map to the council

²⁵⁴ "Council Kills Film Inspection," Times Picayune, Nov. 30, 1912.
which showed that most of the homes on the 2800 block of Third Street were actually Black-occupied. Speaking on behalf of the Council, member Newman stated that although "the majority of residents in the neighborhood are negro and sanitariums must be placed somewhere," he was "impressed" that a location in a "more thoroughly defined negro neighborhood might be found" and also that the proposed location—and its current location in the white Medical District—"might lead to conflict between the races." Swayed by the arguments of the protestors, the council rescinded the permit for the hospital.256

In February, Newman appeared before the council again, asking for permission to build the hospital on Delachaise Street, in the area Ellen Murphy argued was "more of a negro neighborhood."257 The council granted the permit in March 1917, and Newman set to fundraising for building the new hospital.258 That summer, the Moose Lodge purchased the building that housed the Provident Sanitarium in the Medical District. In the seven years since the hospital had opened, the surrounding blocks had increasingly become more valuable as the nearby Central District grew and the white presence in the surrounding area expanded. Upon acquiring the building, new white neighbors immediately petitioned the Moss Lodge to evict the Provident Sanitarium; as described by Black physician L.B. Landry, Newman was "driven from pillar to pest by dissatisfied neighbors."259 The Moose Lodge—which itself had a whites-only membership clause—

complied, evicting the hospital. Newman turned his sole focus to the fundraising for proposed hospital in Central City,

Newman, L.B. Landry, and Landry's wife launched a fundraising campaign, spearheaded by Mrs. Landry, that raised several thousand dollars in four months, with support from U.S. customs inspector Walter Cohen and Dr. George Lucas, president of the local NAACP chapter. The group, which named itself the Colored Hospital Association, needed more, though, to construct the hospital. They approached white leaders, including Mayor O'Keefe who publicly endorsed the project, and the editor of the Times Picayune, Daniel Decatur Moore. Moore urged white readers to give, and personally pledged $100,000 if, he told the Colored Hospital Association "their people and medical men proved worthy." With an initial $14,000, the Colored Hospital Association built a small structure on the Delachaise property, but no white business leaders gave any money, and fundraising stalled. Moore withdrew his pledge, and the hospital efforts collapsed in 1921. An empty building stood on the Delachaise Street lot.

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Like many Black physicians of the period, Landry came from a prominent family with multiple individuals involved in the medical field. Formerly enslaved, in 1868 Landry's father Pierre became the first Black elected mayor of a U.S. town, Donaldsonville, Louisiana; he later served in state legislature for fourteen years and authored the bill to create New Orleans University, as well as serving on Flint Medical College's Board of Trustees. J.B. Landry's brother Eldridge graduated from Flint and ran his own pharmacy in New Orleans. Another brother, Oliver, attended Flint until its closure and then graduated from Meharry. He established his own medical practice in the Dryades Street section of Central City. J.B.—whose full name was Lord Beaconsfield—graduated from Meharry; had a medical practice in Algiers; operated a free clinic for Black residents; taught at Flint; and authored a health column in the Louisiana Weekly titled "How to Keep Well" from 1926-1934. Frank Lincoln Mather, ed., Who's Who of the Colored Race (Chicago, 1915), 170.
for several years as a vestige of the effort. In 1925, Newman died, his memoirs uncompleted and the building on the Delachaise Street lot unoccupied.  

Newman's struggles and the demise of the Providence Sanitarium are not just tragic stories of a forgotten pioneering physician and Black hospital. The removal of the hospital from the Medical District demonstrated a new phase of apartheid health care in the first decades of the twentieth century; this chapter explores that intersection. It examines how New Orleans's push for increasing trade with Latin America and tourism led to civic improvements, public health campaigns, and an expanding health care economy. As boosters promoted New Orleans as a healthy city, with a robust health care system, they also advocated for residential segregation and spatial concentration of Black residents in less-desirable area, often using arguments of poor Black health as justification for removal. This chapter details the push by white leaders to evict Black medical institutions like the Provident Sanitarium, Flint Goodridge Hospital, and Flint Medical College, and the role of municipal powers and federal funding—through programs like the Works Progress Administration—in supporting the efforts to create a white Medical District.

**A Growing Health Care Economy and Public Health**

The growing medical profession—Black and white—in New Orleans was part of the city's expanding health care economy, and mirrored a national trend. Throughout the United States, the perception of hospitals had changed. Previously viewed as charitable spaces for the care of the indigent, by the turn of the twentieth century, hospitals were increasingly seen as a necessary component of health care. Important changes included

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increasing professionalization of practitioners, including standardized education, testing and clinical instruction, professional administration, advances in medical knowledge and treatment, and improvements in medical equipment and sterilization resulting in declining hospital mortality rates. Middle and upper-class Americans were more willing to use hospitals. In particular, surgeries for acute conditions, which were more profitable than long-term care, increased. As a result, private hospitals proliferated, relying not on charity or philanthropic support, but on patient fees. By the 1900s, hospitals had become business enterprises. Although much of the South lagged behind this trend, New Orleans's health care economy grew in the late nineteenth and early twentieth century. As was the case in the antebellum period, small, private hospitals and infirmaries still existed for private physicians to treat their wealthier clients unwilling to use larger hospitals like Charity Hospital or Touro. Several new small hospitals opened in the period. However, the number of these infirmaries would gradually decline, because they were unable to compete with larger hospitals like Charity, Hotel Dieu, and Touro—which had built a larger structure on Prytania Street in 1881. Three new large hospitals joined these ranks, all started by religious organizations: the Presbyterian Hospital in 1910, Mercy Hospital (founded by the Catholic order the Sisters of Mercy) in 1924, and Southern Baptist Hospital in 1926.

With the city's geographic and population growth in the same period, hospitals opened in new neighborhoods along the city's expanding urban periphery. Wary of the

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263 The New Orleans Sanitarium opened in 1886; Beard's Hospital in 1895; Dr. E.D. Fenner's Private Orthopedic Infirmary and Sanitarium for Sick Children in 1905; the New Orleans Dispensary for Women (later Sara Mayo Hospital) in 1905; and Brosnan's Hospital for the Injured 1912.
spread of disease, most residents still did not want hospitals in their neighborhood. When the Southern Baptist Convention announced plans to build their hospital in 1924, white residents unsuccessfully petitioned to halt the placing of the hospital on Napoleon Avenue, but they did successfully petition the city council to only permit the structure to extend into the Black-majority blocks of the Freret neighborhood, rather than the white-majority blocks of the Broadmoar neighborhood. This fight over space—with the designation of Black areas, but not white ones, as acceptable for "hazards"—would characterize the period as the city sought to foster racial segregation, including areas around medical institutions, particularly the medical district. Additionally, as will be discussed in greater detail in following sections, the expansion of hospitals would be linked with disruption of Black neighborhoods and displacement of Black residents.

The area around Charity Hospital (the Tulane Gravier/Central Business District neighborhoods) was still considered the medical district in the early twentieth century. When Charity Hospital relocated there in 1831, the area was largely undeveloped. In the mid- and late-nineteenth century, commercial and later industrial enterprises concentrated there, earning the lasting moniker of the Central Business District. In addition to these businesses, medical institutions proliferated there as well, drawn primarily by Charity Hospital—where many of these institution's leaders were staff members. The University of Louisiana opened close to Charity in 1834, followed by several smaller, private hospitals including Warren Stone's Infirmary in 1837, the Circus Street Infirmary in 1841, and Hotel Dieu in 1858. In the late nineteenth century and early twentieth century, other institutions joined the medical district: the Ear, Eye, Nose, and Throat Hospital in

\[264\] "Petition of Mrs. Bella Levy Marouse and Dr. Percy L Querens," Dec. 8, 1927, City Planning and Zoning Commission Records, CANOPL.
1889, New Orleans University Medical School (later Flint Medical School) in 1889, Flint Goodridge Hospital in 1896, the city's Isolation Hospital in 1905 (for quarantining patients with contagious diseases like smallpox), the afore-mentioned Presbyterian Hospital in 1910; the City Hospital for Mental Diseases in 1911, the Illinois Central Railroad Hospital (open to employees of the Illinois Central Railroad) in 1913, and the Lying-in Hospital (a municipal maternity hospital) in 1917. In addition to following national trends, the expansion of the health care economy reflected city leaders’ recognition of the contributions of the health care sector—physicians, hospitals, and the medical school—in aiding the city's physical and economic development, and even as a key employer.

By the early twentieth century, the growing trade with Latin America—primarily for agricultural products like bananas and coffee—and tourism had become key drivers of the New Orleans economy. Boosters sought to develop business associations, steamship companies that sailed directly from New Orleans to Latin American ports, and foreign trade organizations to make New Orleans the 'Gateway to Latin America'. By 1914, over 75% of imports by value to New Orleans came from Latin America.265 In 1913, the Association of Commerce merged with the New Orleans Progressive Union and the Young Men's Business League. The association created a tourism and convention bureau, and launched a nationwide tourism media campaign to attract visitors and professional conventions.266

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Starting in 1910, to further boost the image of the city, New Orleans civic leaders began a several-year push for the 1915 Panama-Pacific Exposition; they also hoped to be designated the official port of entry when the canal opened. New Orleans competed with San Francisco for the exposition, with extensive business and political lobbying. As part of their effort to win the event, San Francisco underwent a significant municipal improvement and beautification process. Both sides also engaged in smear campaigns. San Francisco pamphlets criticized New Orleans on several fronts: inadequate number of hotels, a less developed commercial sector, lack of "fit drinking water," "unsanitary conditions," and a "big negro population." San Franciscans proudly proclaimed their city as 98% white.\textsuperscript{267} Ultimately, Congress awarded the exposition to San Francisco. The loss demonstrated a continuing problem in the minds of white elites in New Orleans. To attract both visitors and trading partners, the city had to eliminate public health issues and project an image of good health and sanitation. Many outside of the New Orleans viewed the city still as unsanitary and unhealthy due to the city's high mortality rate. Additionally, many whites viewed the large Black population, the second biggest of any American city, as another stigma. In the first three decades of the twentieth century, white leaders of the city sought to combat these issues, first tackling public health, then turning towards segregation.

Through the dawn of the century, New Orleans remained significantly behind other major American cities because it had no sewer or drainage system, no garbage collection, refuse and open trash containers throughout the city, no street cleaning, high grass on lots, wooden plank sidewalks, and unregulated ownership of domestic animals

\textsuperscript{267} Gotham, \textit{Authentic New Orleans}, 77.
and storage of foodstuffs. These issues favored the estimated one million rats in the city. Open pools of water like cisterns served as breeding grounds for mosquitos that served as vectors for yellow fever and malaria, New Orleans had a malaria rate of 104 per 100,000 in 1900. The use of privies rather than a sewer system led to the mixing of human waste and drinking water, which facilitated outbreaks of typhoid and cholera; the typhoid rate was 38 per 100,000 in 1900.²⁶⁸

The municipal government, with the backing of the medical system, initiated efforts from 1900-1940 to deal with the scourges that continued to afflict the city, notably malaria, tuberculosis, typhoid, and yellow fever.²⁶⁹ The city focused on improving public health knowledge, eliminating sources of contagion by closing open pools of water like cisterns and privies, initiating mosquito control, paving roads, the raising of buildings, creating modern sewer, drainage, and sanitation systems, and providing better treatment through public health clinics.²⁷⁰ Of the public health problems, tuberculosis received perhaps the most attention as it remained one of the highest causes of death with a mortality rate of 326 per 100,000 residents from 1900-1904, one of the nation's highest

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²⁶⁹ New Orleans suffered the last yellow fever epidemic in the U.S. in 1905 with an outbreak that killed 437 people
²⁷⁰ Outbreaks of bubonic plague in 1914 and 1919 led to mass rat extermination campaigns and rat-proofing measures that significantly changed the city. A new municipal ordinance passed in 1914 mandated buildings' floors to be at least 18 inches off the ground; by February 1915, over 150,000 buildings had undergone rat-proofing and raising at a cost of over ten million dollars. "Plague," Public Health Reports 30, no. 8 (February 1915), 545. "Drastic Laws to Be Adopted For All The City Ratproofing of New Orleans Is Deemed," Times-Picayune, July 15 1914. "City Board of Health Minutes," July 14, 1914, New Orleans Health Department Records CANOPL.
rates. In 1906, activist Kate Gordon organized the New Orleans Tuberculosis League which partnered with the Louisiana Anti-Tuberculosis League to provide free TB clinics, and pushed for the opening of the Orleans Anti-Tuberculosis Hospital in 1926 in the Gentilly neighborhood and the John Dibert Tuberculosis Hospital, also opened in 1926 as part of the growing Charity Hospital complex.

Tulane University became actively involved in both public health and hygiene issues. In 1912, Dr. Creighton Wellman founded the New Orleans School of Tropical Medicine and Hygiene as part of Tulane University. Samuel Zemurray (nicknamed "Sam the Banana Man"), who owned Cuyamel Fruit which shipped fruit from Honduras to New Orleans, funded the school, further demonstrating the ties between the commercial trade industry and public health measures. In October 1912, Wellman published "The New Orleans School of Tropical Medicine and Hygiene," a lecture he originally delivered before the OPMS in March 1912. In his paper, Wellman highlighted the international shift towards "preventative medicine," and made the case for New Orleans as an important center in this new approach. Wellman argued that with the creation of the school, New Orleans would be the center of a "great movement for the study and conquest of disease, and particularly tropical disease." New Orleans and Tulane, he posited, were "marked for a great and manifest destiny of educating the

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272 Pierre Buekens, "From Hygiene and Tropical Medicine to Global Health," *American Journal of Epidemiology* 176, no. 7 (2012): S1-S3.
273 Zemurray later served as president of the United Fruit Company and was one of the wealthiest men in the world, with many donations to Tulane University. For more on Zemurray, see Rich Cohen, *The Fish That Ate the Whale* (New York, NY: Farrar Straus Giroux, 2012).
Western Hemisphere in the vital questions of riddling ourselves of the disease scourges which have too long hindered the commercial, social, and moral growth of the many."

In his view, and those of other trade boosters, New Orleans, as a major trading port for Central and South American, made a natural choice to be the central location for studying the eradication of tropical disease like yellow fever, malaria, and typhoid. Tulane would train the "future custodians of health," providing education along the "broadest possible scientific lines" based on the recent advances in bacteriology, pathology, and laboratory science. Wellman also pledged to work with the Board of Health, other government and civic officials, educators, and the general public to educate about and confront the city's public health problems.274

By 1920, New Orleans had undergone a radical shift in its approach to public health. The city employed what were considered to be "progressive" and "scientific" approaches to shift away from reaction to prevention of epidemics through education; civic improvements, including drainage, water, and sewage lines; sanitation and hygiene initiatives; and new clinics and hospitals to not only tackle public health problems, but to also boost the city's trade and tourism image, which would make New Orleans again a leading center of medicine.

A White Medical District

Buoyed by municipal leaders, economic boosters, and increasing federal medical research funding, the city's most significant medical institutions—Charity Hospital and Tulane University—underwent significant expansion in the early twentieth century by acquiring numerous blocks in the Medical District. Charity built the Richard Milliken

274 Creighton Wellman, "The New Orleans School of Tropical Medicine and Hygiene," 1912, C.C. Bass Papers, LRCTU.
Memorial Children's Hospital in 1899, the Delgado Hospital in 1909, and the John Dibert Tuberculosis Hospital in 1926 as part of their complex, in addition to an ambulatory building, nurses' residences, and support units (laundry, power). Tulane moved their medical program into the nearby Richardson Building in 1893 on Canal Avenue, renovated and expanded in 1902 and renamed it the Josephine Hutchinson Memorial Building. In 1922, the City Council granted Tulane's initial request to construct their own hospital on their campus.\textsuperscript{275} Ultimately, the Board of Administrators decided not to go forward with their hospital plan, and instead built the new Hutchinson Memorial Building on Tulane Avenue, which contained a clinic with hospital beds, next to Charity Hospital in 1930.\textsuperscript{276} A second medical school joined Tulane in the Medical District. In 1931, the Louisiana State University School of Medicine opened. Pushed by Governor Long, who wanted to create a medical school for residents of the state—most of Tulane's students came from outside of Louisiana—the school constructed a building on Tulane Avenue, across from Charity, on land owned by the hospital. Despite initial opposition from Tulane and legal challenges, the school enrolled 171 students for its first full year of operation in 1932, with a faculty largely raided from Tulane—further drawing their ire. The two schools agreed to have an equal number of beds at Charity, partially mollifying the private school.\textsuperscript{277}

As the hospital and medical schools expanded, the institutions and white city leaders began removing the Black presence in the medical district, which was part of a larger push for segregation and spatial concentration of African Americans. Throughout

\textsuperscript{275} No. 609 C.C.S. 1922, Commission Council Series, CANOPL.
\textsuperscript{276} No. 11271 C.C.S. 1929, Commission Council Series, CANOPL.
\textsuperscript{277} Russell C. Klein, \textit{A History of LSU School of Medicine New Orleans} (New Orleans: LSU Medical Alumni Association, 2010), 1-5.
the early twentieth century, New Orleans had relatively low levels of segregation, primarily due to African Americans living close to white residences where they labored as domestics. This changed in the early twentieth century. With the expansion of municipal services like drainage, water, sewage, and roads, neighborhoods on the urban periphery (like the 7th, 11th, 15th, 16th, and 17th wards) previously considered undesirable and flood-prone—and thus having higher concentrations of Black residents due to low property values—became appealing for white residents.

To aid white acquisition of these areas and to concentrate African Americans in the neighborhoods that still lacked municipal services and were most flood-prone, whites employed discriminatory real estate practices. They used their municipal powers, particularly the city's residential segregation ordinance and racial zoning, and extralegal measures, like violence.

Following the lead of other Southern cities starting with Baltimore in 1910, New Orleans adopted a residential segregation ordinance in 1924; they did so despite the Supreme Court declaring such ordinances illegal in the 1917 case Buchanan v. Warley. New Orleans's city leaders justified the ordinance as a defense of white property values, arguing that African American residents in neighborhoods would decrease the values. These measures were ostensibly taken to prevent racial animosity and violence, and as a public health measure because African Americans had higher disease rates and would

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spread disease to whites. In the following three years, white residents would use the ordinance, backed by police threats of arrest and acts of violence including a series of bombings of Black homes and businesses, to prevent African Americans from moving not only into predominantly white blocks, but also into many racially mixed neighborhoods, or spaces that whites hoped to claim as their own after city improvements made those areas desirable to live. Thousands of African Americans were directly affected, charged with violating the law, prevented from moving into homes they had legally purchased or rented, and made to sell property they owned to whites at losses—even though the city's improvements had significantly increased their property value.

Although lawsuits by Black residents, later supported by the local chapter of the NAACP, led to the Supreme Court declaring the ordinance unconstitutional in Harmon v. Tyler in 1927, efforts to expand segregation continued into the following decades. White residents and police officers continued to harass and attack African Americans that attempted to live in or even access areas considered to be "white spaces." Developers and homeowners instituted racially restrictive covenants to prevent the renting or selling of homes to African Americans. Most significantly, in 1929, the city instituted its first comprehensive zoning plan. Drafted by nationally renowned planner Harland Bartholomew, the document employed "racial zoning" practices to propagate segregation. The plan designated mostly white neighborhoods as "residential A," permitting only single or double family homes. With this rule, whites could build individual homes with racially restrictive covenants, and prevent the building of apartment buildings, which

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280 For more on these bills and their justifications, see Carl Nightingale, "The Transnational Contexts of Early Twentieth-Century American Urban Segregation," *Journal of Social History* 39, no. 3 (Spring 2006): 667-702, 676.

281 1929 New Orleans Comprehensive Zoning Ordinance.
African Americans may have been able to afford. The plan designated Black neighborhoods as "Multiple Dwelling," which permitted apartment buildings; "Unrestricted," which allowed any building type, including industrial plants; or "Industrial." The plan also placed industrial zones adjacent to the Black residential "multiple dwelling" neighborhoods. Beyond contributing to the spatial containment of African Americans, the comprehensive plan codified Black exposure to health hazards, particularly air and water pollution from industrial plants.²⁸²

By 1930, New Orleans had redefined urban space. The laws, real estate practices, white violence, and zoning had increasingly concentrated African Americans in neighborhoods viewed as undesirable. The city coupled these practices with new ordinances passed after World War I that ordered racial segregation of public spaces and entertainment venues like parks, museums, bars, restaurants, and sporting events, designed to attract white tourists from the north.

White leaders subjected the Medical District to these segregation efforts, using their powers to remove the growing Black medical system in the neighborhood. By the 1910s, in addition to Flint Medical School, Flint Goodridge Hospital, and J. T. Newman's Provident Sanitarium, Black physicians' offices and pharmacies dotted the area. The Pythian Temple, on Loyola Avenue, contained the offices of several doctors, dentists, and life insurance companies. Thus, the Tulane Gravier neighborhood served as the primary medical district for African Americans in the early twentieth century, as it did for whites.

Flint Medical College was the first institution removed. In 1910, Flint Medical College officials planned a $50,000 enlargement of the building by 50 percent, in the hopes of allowing more students, and to meet new standards established by the American Medical Association. In 1904, the American Medical Association created the Council on Medical Education (CME) to study and standardize medical education. The CME asked the Carnegie Foundation to fund a study, led by Abraham Flexner, of all medical colleges in the United States. The 1910 Flexner Report faulted Flint Medical College for having "scant equipment in anatomy, chemistry, pathology, and bacteriology" and described the rooms as "in poor condition." The report concluded that "Flint College is a hopeless affair, on which money and energy alike are wasted," and recommended closing the school and redirecting all of Flint's students and resources to Meharry College in Nashville, which it opined should be the only school for Black physicians in the south. While having no official authority to close schools, the report warded off needed donors from the schools criticized in the document, mostly Black medical colleges, and the AMA instituted new accreditation guidelines based on the report. Unable to secure funding to changes mandated by the AMA to maintain accreditation, Flint Medical College closed in 1911, one of five Black medical colleges that closed due to the Flexner Report, leaving only two programs open, Meharry and Howard. All Flint students transferred to Meharry, although periodic efforts to reopen the school continued for several years afterward. During its existence, Flint Medical College produced a total of 102 doctors, hailing from eight states and the West Indies, and 62 pharmacists. The loss
City officials used municipal powers to temporarily close Flint Goodridge Hospital as well. An inspection by the city board of health found the hospital structure to be unsafe, and after administrators were unable to raise money to make improvements, they closed the facility in 1912. Hospital leaders eventually secured additional financial support from the MEC, Caroline Mudge, and the descendants of John Flint, and converted the empty medical college building into a new sixty-bed hospital, renamed Flint Goodridge Hospital and opened in January 1916. Black and white community leaders including Mayor Martin Behrman attended the dedication ceremony. Reporters described the new space as "modern, convenient, and well equipped." However, the new building lasted less than fifteen years.

In 1926, Charity Hospital sought to further erase the Black presence in the Medical District by making Black patients less visible. Since 1877, the hospital had segregated patients, for decades by using a smaller building on Gravier Street, behind the main building on Tulane Avenue, as the "colored ward." In 1926, the hospital announced a change in its policy, now requiring African American patients to use a separate entrance on Gravier Street, rather than the main one on Tulane Avenue. Black leaders immediately

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condemned the action, with board members of the NAACP local branch—led by physicians Dr. George Lucas and Dr. Joseph Hardin—presenting a petition of protest signed by hundreds of residents. Black leaders framed their opposition in several ways. First, they presented an economic argument, highlighting the unfairness of the policy due to the financial contributions to the institution and the city as whole, as laborers, taxpayers, and donors to hospital fundraising drives. Second, they argued the unfairness of the policy in light of decades of "embryo physicians" at Charity—medical students, interns, and new residents—learning by practicing on Black patients. The NAACP's petition states that African Americans had "contributed more than his share of subjects for studious consideration of the white novice. He has been a veritable storehouse of knowledge to the embryo pathologist." The Louisiana Weekly was even more critical, writing of "the living sacrifices they have made in their bodies and their very lives for the sake of making physicians—white physicians, if you please."

Black leaders also noted the connection between the policy and the city's residential segregation ordinance, at that time still awaiting a ruling by the Supreme Court. The NAACP told the Board of Administrators that they had "inadvertently permitted its policy to be shaped so as to put the institution in the same category with certain persons…who not only advocate public segregation but whose teachings and doctrines tend to the most injurious form of racial oppression." Both the Weekly and the NAACP highlighted their opposition to all forms of "public segregation," describing it as

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286 Many Civil Rights activists made similar claims to argue for access to other segregated spaces. For example, Black residents of South Florida argued that paying taxes should have allowed them access to whites-only beaches. See Nathan Connolly, A World More Concrete: Real Estate and the Remaking of Jim Crow South Florida (Chicago: University of Chicago Press, 2014).

287 "Charity Hospital and Segregation," Louisiana Weekly, April 24, 1926.
"unjust," unnecessary," and "embarrassing." The NAACP noted that whites cited avoiding racial conflict as a reason for segregation, but Charity's policy would have the opposite effect, planting "deep in the heart of every self-respecting Negro the seeds of discontent, dissatisfaction, and unrest—yea even rancor." Charity's Board of Management responded that they did not intend the "result of racial discrimination" with the policy, but rather "to facilitate the movement of the crowd," refused to accede.\(^{288}\)

While African American leaders spoke of their opposition to "all forms of public segregation," their petitions were limited in scope. Black leaders did not call for the end of the fifty-year policy of segregated treatment at Charity. Instead, they pushed for the enforcement of the "equal" part of the court's "separate but equal" provision. The local NAACP chapter—dominated by upper class medical professionals in six of the eight executive board positions—and the Federation of Civic Leagues favored an "accommodationist" over an integrationist approach in the period. They propagated Booker T. Washington's model of "rational uplift," with the "better class" leading the effort to improve the standing of African Americans and gain acceptance by whites.\(^{289}\) They sought smaller concessions over radical changes like integration, instead pushing for better funding for separate Black spaces like schools, parks, and playgrounds, and municipal services for Black neighborhoods. Similarly, at Charity, they requested not


integration, but instead equal funding for the Black ward and equality through using the
same entrance.²⁹⁰

White leaders ignored these petitions, and the apartheid medical system grew, and
it was increasingly fueled by federal funding. Passed in 1933 in response to the Great
Depression, the National Industrial Recovery Act created the Public Works
Administration, which funded public works including schools, bridges, and hospitals. In
1933, Charity applied for Public Works Administration funding to build a larger hospital,
a move opposed by the Orleans Parish Medical Society, who viewed the expansion as
detrimental to other private hospitals, and argued Charity had too many beds. With
opposition from the OPMS, as well as a frosty relationship between President Franklin
Roosevelt’s antagonist Governor Huey P. Long and the federal government, the PWA
delayed approval. Despite the OPMS's claims, Charity was overcrowded and
underfunded, as it had been through much of its existence. In 1936, the hospital served an
average of 2,781 patients daily in a space that contained 1,814 beds.²⁹¹ This problem
particularly afflicted the Black ward, with many patients forced to sleep two or three to a
bed, or on cots and wooden pallets in the halls.²⁹² When Morris Fishbein, the editor of the
Journal of the American Medical Association, inspected Charity in 1936, he publicized
his findings, drawing national attention to the "horrible conditions" of hygiene and
sanitation he found in the Black ward.²⁹³ This report and coverage in Time Magazine led

²⁹⁰ For more on this generation of Civil Rights leaders, see Sharlene Sinegal
Decuir, "Attacking Jim Crow: Black Activism in New Orleans 1925-1941" (Dissertation,
Louisiana State University, 2009).
²⁹¹ Lincoln, "The History of Tulane University's School of Medicine's
Involvement with Charity Hospital."
to further calls for improvement, and the federal government approved funding in 1936—after the assassination of Governor Long.

The new Charity, the second largest hospital complex in the country with 2,860 beds in the main structure and an additional 850 beds in affiliated buildings, took three years to construct and cost four million dollars over budget due to widespread graft. Through the PWA, the federal government paid 45% of costs, including "slum clearance" measures to clear out the surrounding blocks for the much larger hospital. This action—physically carried out largely by Black WPA laborers—displaced hundreds of African American residents and businesses—including Black pharmacists, the last remnants of the African American part of the medical district—and churches, as well as the Chinese business district on Tulane Avenue. African Americans remained the majority of residents of the neighborhood. In 1939, the Home Owners' Loan Association noted that Tulane Avenue, which housed Charity, was 100% white and contained "the best properties in the area"; overall, though, the association gave the surrounding Black neighborhood its lowest rating, as "hazardous." The characteristics contributed to redlining, the practice in which the Federal Housing Administration refused to grant insurance to loans and mortgages for homes in areas identified by the Home Owners' Loan Corporation maps as "declining" or "hazardous." Private lenders including local banks in New Orleans too used the maps as guidance. Because almost all Black neighborhoods were designated as "declining" or "hazardous," Black residents in Tulane Gravier and other Black-majority neighborhoods faced extreme difficulty in securing

\footnote{294 Richard Campanalla, \textit{Cityscapes of New Orleans} (Baton Rouge: Louisiana State University Press, 2017), 53.}
necessary loans or mortgages to become home-owners. Charity, Tulane, and LSU would all expand in the following decades, pushing more and more African Americans outside of the neighborhood, and further away from medical care. Like Charity, federal funding also funded the growth of Tulane and LSU—and indirectly the displacement of more African American residents. Both hospitals benefitted from federal grants that helped the schools expand their programs, student numbers, and their physical presences.

**New Orleans as a "Medical Center"

In 1929, physician CC Bass gave a speech to OPMS entitled "New Orleans as a Medical Center," which detailed many of the medical and public health improvements of the city, celebrated the Crescent City as the leading medical center of the South, and highlighted the importance of the medical field to the city's economic prosperity. Bass held up the city's hospital facilities as "unequalled in the South" and New Orleans as the "leading center for the entire South and Southwest for almost one hundred years." Bass noted the significance of the medical field in sustaining trade with Central and South America. In fact, he argued, New Orleans had become the place for which the surrounding Southern territory and "tropical countries" turned to for research on tropical disease. Thus, in Bass's opinion, New Orleans was not just a key site for medical care, but also a leading medical research center. The "researches and contributions of the medical profession of New Orleans," he stated, "have commanded attention and high esteem in every civilized country in the world." As such, it attracted medical students

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from every state in the U.S. and internationally, especially increasingly from Central America and South America due to the "tropical disease research" and the "rapidly increasing number of patients." The color line that rejected African Americans as doctors and medical students did not apply to individuals from Central and South America who could attend the city's two medical schools, join the OPMS, and work in the private hospitals. The benefits of this tropical research to Latin American countries and the training of medical students from there, in his view, greatly improved the relationships between New Orleans and Latin America, leading to "increasing friendliness in matters of business and commerce." Bass opined that the future of New Orleans, the "Queen of the South," depended on this trade relationship and its broader role as a major port city, which relied heavily upon the medical field: "As a city's health is a city's wealth, so shall this phase of our civic development keep pace with our commercial advancement."

With these growing institutions fueled by federal funding and support from economic boosters, by the 1930s New Orleans had returned to its pre-Civil War status as one of the leading medical centers of the South. In addition to being home to the nation's second largest public hospital, a boom in hospital construction in the 1910s and 1920s expanded the capacities of the French Hospital, Presbyterian Hospital, the Ear, Eye, Nose, and Throat Hospital, Hotel Dieu, and the U.S. Marine Hospital; two medical schools, with hundreds of students; and hundreds of practicing physicians. The city also offered nursing programs at Charity Hospital (started in 1895), Touro Infirmary (1896), Flint Medical School (1896), Hotel Dieu (1899), and the New Orleans Hospital and Dispensary for Women (1908). Thousands worked directly or indirectly in the city's
health care sector and by 1930, the hospital industry became the fifth-largest enterprise in the country.296

Bass noted "With the worthy record as a medical center for the past and present that New Orleans has, the future can hold only increasingly glowing prospects." He identified Tulane University—where he taught—as the heart of the burgeoning medical center. Bass praised Tulane as a "center for medical knowledge," and argued that the school's continued development "will greatly increase the importance of New Orleans as a medical center."297

Bass was not the only physician to hold these views. In his 1931 inaugural address, incoming OPMS president Emmet Irwain held up New Orleans as "one of the nation's leading centers for the dissemination of medical knowledge." Irwain used his speech to call for increased funding for medical research, of vital importance to the city: "When the dividends are declared through extermination of disease, relief of suffering, better health, prolongation of life, and a more desirable community in which to live, the investment is quite small." Greater federal aid and other forms of funding would allow New Orleans, as a "famous Medical Center," to "take the lead in vast research problems and claim her just position in the medical world."298

In many ways, Bass and Irwain's assessments were correct. The growth in the number of hospitals and the larger health care economy, and improvements in medical research had greatly aided the city's economic development and improved the health and lives of many. However, the health efforts mostly benefitted white residents and excluded

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296 Starr, *The Social Transformation of American Medicine*, 111
297 "New Orleans as a Medical Center," C.C. Bass Papers, LRCTU.
298 "Inaugural Address of Emmet Irwain," January 6, 1931, OPMS Collection, LRCTU.
African Americans. Tulane became integral in New Orleans's success as a medical center, as it produced many of the city's leading physicians and surgeons, and also served as main center for the city's research in tropical medicine, largely funded by federal grants. But, African Americans could not attend Tulane or LSU, or any medical school in the Deep South; nor could they join the OPMS or work as a nurse or physician at any hospital in the city except at Flint Goodridge. All private hospitals, including the newly opened institutions, supported Jim Crow by refusing to admit Black patients. Black patients in the "leading medical center of the South" could only use Flint Goodridge or Charity, the latter of which also upheld Jim Crow in its new hospital. When the federal government approved PWA funding to construct a new Charity, many in the African American community hoped the complex would provide better care for Black patients. "With this announcement," reported the *Louisiana Weekly*, "comes hope on the part of Negroes of Louisiana that adequate provision will be made for them." This hope did not materialize.

During the three years it took to construct the new building, the hospital temporarily transferred Black patients to the Pythian Temple. Because the Knights of Pythias chapter owed several years of back payments, the state forced the organization to rent the space, which contained the offices of Black physicians, the Liberty Industrial Life Insurance Company, the Douglass Life Insurance Company of Louisiana, and *Louisiana Weekly*. Some businesses stayed on the ground floor, while others, including the physicians were forced to relocate. Black New Orleanians looked upon the move with suspicion. One newspaper columnist saw the action as a "subtle movement to

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remove Negro property owners from the immediate location of proposed new City Hall."

The state attempted to force the Knights of Pythias to sell the space by auction (with white ownership likely). However an attorney for the Knights of Pythias successfully blocked the move at the U.S. Circuit Court of Appeals in 1937, and maintained the Knights as the owners. 

Local Black business and civic leaders then "banded together for the common good" to help the Knights secure a loan saving "the most valuable real estate owned by Negroes in Louisiana." During its three-year occupation, hospital administrators made some repairs to the building, but the same problems of overcrowding and poor funding in regards to Black patients continued. Fishbein of the AMA reported "terrible conditions" after visiting in November 1937, noting that he found 27 patients in 10 beds and infected tuberculosis patients being held next to children.

Black New Orleanians were most affected by the temporary closure of Charity between 1936 and 1939. Beyond the limited space in the Pythian Temple, which contained fewer beds than the Black ward at Charity, Black patients' only other choice was Flint Goodridge. White patients could turn to over twenty other hospitals in the city. When the new Charity Hospital building opened in 1939, the same discriminatory treatment continued. State hospital laws required segregation in all aspects of medical treatment at the hospital. The hospital had a separate "colored ward" in a different wing from whites; required African Americans to use a separate entrance; and kept a separate Black blood bank. White and Black patients shared a waiting room, with separate seats

for each race. However, fewer seats existed for Black patients. Even if all the Black seats were full and white seats were unoccupied, security guards prevented Black patients from using those seats. As a result, Black patients often had to stand for up to seven hours waiting to be seen.\(^\text{304}\)

Physicians at Charity in the period continued the legacy of experimentation on enslaved patients from the antebellum period. Former Charity Hospital chief of staff John Salvaggio told a 1994 Congressional inquiry, "The whole population of the hospital was used for guinea pigs…You could pick anyone you wanted and do any tests you wanted"\(^\text{305}\) In the 1950s, the Atomic Energy Commission sponsored fifteen different radiation studies at Charity, which were carried out by doctors affiliated with Tulane University and led by Dr. George Burch. These tests on 300 Black patients included having them swallow radioactive mercury without their consent or knowledge of the dangers. This was part of a larger series of studies carried out by the AEC on Black hospital patients nationwide.\(^\text{306}\)

Segregation and exclusion persisted in other health care institutions and endeavors, including the city's celebrated public health measures. For example, the private TB sanitariums and retreats located on the other side of Lake Pontchartrain—including the New Orleans Anti-Tuberculosis League's Camp Hygiea—refused to admit Black patients. The Anti-Tuberculosis League clinics and Orleans Tuberculosis Hospital—founded by activist Kate Gordon—only treated African Americans as out-

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\(^{305}\) Jim Carrier, *Charity: The Heroic and Heartbreaking Story of Charity Hospital in Hurricane Katrina* (Lakewood: Ranger Media, 2015), 30.

patients in separate, smaller, and under-funded clinics. Only Flint Goodridge Hospital and Charity Hospital accepted Black tuberculosis sufferers as in-patients, and the latter only in a small, segregated space in the old hospital, reserving the entire newly opened John Dibert Tuberculosis building for whites only. The city's focus on white citizens, and refusal to address the root causes of tuberculosis that disproportionately affected African Americans—like poverty, poor quality and overcrowded housing, malnutrition, and unequal access to health care—kept the Black tuberculosis rate three times the rate for whites through the 1930s.³⁰⁷

To compound this exclusion, white officials and physicians blamed African Americans for their public health problems like tuberculosis—caused by the factors listed above, all stemming from Jim Crow segregation and discrimination—and used these castigations to support their segregation efforts. One example was Rudolph Matas, a professor at Tulane, doctor at Charity, and one of the nation's leading surgeons. In his 1896 paper "The Surgical Peculiarities of the Negro," Matas argued that whites were physiologically "the superior race," and that "mulattos" were "liable to disease" like tuberculosis which they could spread to whites. Matas used these claims to advocate against "miscegenation."³⁰⁸ This pseudo-scientific claim of biological inferiority that Matas and other leading white physicians in New Orleans and elsewhere propagated represented an intellectual lineage that traced back to the pro-slavery writings of figures like Samuel Cartwright. In their 1906-1907 Biennial Report, the Louisiana Board of Health stated that "improvement in the colored death rate has been retarded by the

reckless and improvident ways of the race and their utter disregard of all hygienic and sanitary laws”; they recommended separating TB rates by race so as to avoid negative views of whites by outsiders.\(^{309}\) These calls for separation of health statistics transformed into the demands in the 1910s and 1920s for residential segregation and spatial containment previously detailed. All of these ideas rested on notions of scientific racism propagated by the apartheid medical system.

Excluded from the public health measures and the main medical system in general, and blamed for their own health problems, Black New Orleanians in the first decades of the twentieth century turned to creating their own health care system. Black civic organizations initiated public health measures, and Black medical professionals created their own alternate medical district in Central City; chapter five explores these efforts.

\(^{309}\) "Louisiana Board of Health, "1906-1907 Annual Report."
CHAPTER 5: JIM CROW BLACK HEALTH CARE, 1927-1950

Introduction

On October 30, 1931, over 15,000 people came for the dedication of the cornerstone for the new, but not yet opened, Flint Goodridge Hospital in Central City. Grand Marshall Joseph P. Geddes and the graduated nurses from the hospital's training program led a parade of thousands of members of fraternal organizations, civic associations, social clubs, and school marching bands. The Tonic Triad military band and a chorus of 150 singers led the crowd in a rendition of the "Negro National Anthem," followed by a series of speeches by Bishop R.E. Jones, Dillard University board vice president Dr. Emile J. LaBranche, master of ceremony Edgar B. Stern, U.S. Veterans Hospital Superintendent Col. E.H. Ward, and Southern University President Joseph S. Clark. The speakers all lauded the success of the fundraising efforts for the building, with contributions from both white and Black citizens and organizations. The problem of one group is the problem of another," Stern told the crowd. Clark echoed this theme: "the unselfish cooperation of the white people of New Orleans and the state to safeguard the health of the colored people is one of the best evidences of their faith in cooperation." He also urged further contribution from Black residents through their wills and donations, "leaving to the outstanding credit of the race a glorious heritage."

Clark furthermore summarized the importance of the health care system, which had been seen in the proliferation of hospitals throughout the country in recent years, and a corresponding decrease in many rates of disease and mortality. The expanded Flint Goodridge too would address these problems, and provide training for many Black medical professionals, providing invaluable service to the community:
Disease, poverty, and crime have linked themselves together and stared civilization in the face as a mighty monster, waging war against prosperity, peace, and happiness, but fairness and justice are demanding that these monsters surrender their claim, and to that end thousands of hospitals have been erected, making it possible for the sick to be cured, and the lame to walk, the blind to see, and the deaf to hear...This is a unit of the great Dillard University where nurses will be trained and sent forth to the bedside of the suffering with a balm of comfort; where doctors will come and get their interne practice, and go forth to cure; where patients will be brought and their lives extended by the treatment of operation.310

Builders completed the hospital, one of the largest Black hospitals in the country, the following year. Hundreds of thousands of dollars in donations from Black and white residents, as well as philanthropic groups like the Rosenwald Fund, made possible its construction. However, as this chapter will demonstrate, it was hardly an example of benevolent interracial cooperation that guided the giving by whites, as the speakers in 1931 led the crowd to believe. The same desires of racial segregation and spatial concentration that led to Flint Goodridge's removal from the white Medical District instead served as the main impetus for most whites' support. Nevertheless, Joseph S. Clark's assessment of the significance of the hospital proved correct. Over the next five decades, Flint Goodridge would spearhead the effort to tackle Black public health issues. The hospital would also train generations of nurses and physicians. And, Flint Goodridge would anchor a new Black medical district.

This chapter explores the efforts of Black New Orleanians to create an alternate medical district in the Central City neighborhood. It details the initial attempts to create two hospitals, the unsuccessful Colored Hospital, and the new Flint Goodridge Hospital. The chapter examines the initial challenges of the hospital—like fundraising and

staffing—and the vision of Flint Goodridge as not just a hospital but a Health Center focused on three main goals: expanding hospital care for Blacks throughout the region, addressing the public health issues facing the Black community, and serving as a training center for Black medical professionals. Finally, the chapter explores two significant issues for the hospital: the deliberate effort of the municipal government to prevent the growth of the hospital with WPA-sponsored "slum clearance" and building of public housing units around the institution, and the post World War II exodus of Black physicians from the Jim Crow city.

**Creating a Black Medical District**

Excluded from official public health initiatives and blamed for their high disease rate, African Americans attempted to address these problems through grassroots efforts. Black churches and civic organizations participated in public health campaigns and neighborhood cleanups as part of the National Negro Health Week, started by Booker T. Washington's Tuskegee Institute in 1915. In 1927, Dr. Joseph Hardin formed the Seventh Ward Civic League, an organization meant to represent and improve the neighborhood. The organization followed the self-help and accommodationist model promoted by Hardin and other leaders of the local NAACP chapter. Led primarily by upper-income Black business and civic leaders, the Seventh Ward Civic League—and other leagues that formed in other Black-majority wards—carried out neighborhood cleanups, pressured the city for more funding for Black schools, lobbied for the creation of Black parks and
playgrounds, and self-funded street lighting, paved roads, and other improvements the municipal government refused to fund in Black neighborhoods.\textsuperscript{311}

Flint Goodridge Hospital, too became involved in these endeavors. The hospital extended its reach beyond its walls by offering outpatient clinics in schools, charity, institutions, and churches. However, the hospital's clinics, and the grassroots efforts could not overcome the impact of systemic racism, particularly the exclusion from the larger medical establishment, to adequately meet the needs of the city's 99,000 Black residents, or the 1.5 million African Americans who lived within a 200-mile radius of New Orleans. Black leaders still favored the accommodationist approach of pushing for gradual change and enforcement of the equal provision of "separate but equal" over pushing for integration of white hospitals. Angered by the requirement of using the separate entrance and facing continued discrimination and lower quality of care at Charity, Black leaders focused on three different approaches: the creation of a separate "Jim Crow" Black public hospital; the creation of a second private Black hospital; or the expansion of Flint Goodridge. Although addressed as an option in the \textit{Louisiana Weekly}, no existing historical records indicate that African Americans leaders approached the city or the state for the creation of a municipal or state-administered and financed separate Black hospital. Instead, they focused on the latter two options, in the process creating a division within the Black community.

By the late 1920s, many African Americans had lost confidence in Flint Goodridge Hospital's leadership. An all-white board appointed by the Methodist Episcopal Church ran the institution, and selected the hospital's superintendent—who was always white—which rankled many members of the Black community. This model of white leadership existed in many of the Black hospitals funded by institutions like the MEC and philanthropic groups like the Rockefeller Foundation. Frustration with this situation, especially over allegations of prejudice and abuse by white doctors at the hospital, including Superintendent T. Restin Heath, boiled over in the late 1920s. In 1925, Black nursing students went on strike over "unbearable conditions," alleging that Heath was "overbearing" and refused to call them by their surname, only by their first name, a practice of disrespect dating back to slavery in which many enslavers renamed enslaved individuals and often gave no surname, in the process stripping them of their identity and status as equals. Physicians claimed that the Heath bore "anti-Negro feeling," favored white physicians, acted "discourteous" to Black physicians, and only hired whites for his personal office staff. A Black patient made a formal complaint against another white doctor at the hospital, alleging that the physician beat him, prompting investigations by the NAACP. Although Heath promised to give Black physicians a voice in administration, Black doctors and nurses continued to feel disrespected and ignored. In March 1926, officials from the MEC visited the hospital, and Heath offered his resignation; the MEC refused, and told Black leaders who requested a Black physician take his place as superintendent that it was an "idle dream for anyone to figure that a colored man would be made head of the institution as long as the white people, through

[312 For more, see Gamble, Making a Place for Ourselves.]
the church agencies, supplied the money for the hospital. In August 1926, Heath reorganized the staff, and he purposely omitted Dr. Rivers Frederick, his most vocal critic. Outraged, Black medical and civic leaders demanded the restoration of Frederick to the hospital staff, and the MEC's immediate removal of Heath, which the MEC again refused to do.

With the African American community angry at both Flint Goodridge and Charity Hospital, a third hospital for Black patients nearly came to fruition. In 1926, several of the board members of the Colored Hospital Association, which had halted their efforts to build a Black hospital in Central City in 1921, resumed their quest. The Louisiana Weekly heartily endorsed the project, stating in September 1926 that the one good thing that emerged from the "disgusting and muddled situation" at Flint Goodridge Hospital was that it "impressed upon the people of New Orleans the need of another hospital in the city." Similarly, they wrote of the "Uncharitable Hospital": "

We are not wanted at Charity Hospital...Give Negroes a separate hospital where they won't feel as though they are not fit subjects...If we must sacrifice our bodies for the making of physicians, permit us to make a few Black physicians.

Noting that it did "not mean to discard the existing hospital," the newspaper urged Black residents to support this second Black hospital "that serves without being circumscribed by denominational lines"—taking direct shot at the MEC—and "which can appeal to and serve the whole people.

313 "Dr. T. Restin Heath, Flint-Goodridge Supt., to Quit," Louisiana Weekly, March 20, 1926.
314 "Hospital Situation is Acute," Louisiana Weekly August 21, 1926.
315 "A Hospital Tangent," Louisiana Weekly, Sept. 5, 1926
316 "The Uncharitable Hospital," Louisiana Weekly, May 8, 1926.
By late September 1926, the Colored Hospital Association announced plans for a $300,000 dollar, 200-bed institution—with half the beds allocated for free service for indigent patients—on the same lot purchased by Newman in Central City, far exceeding the hospital they had hoped to build five years earlier. This eclipsed the 64 beds in operation at Flint Goodridge at the time. Additionally, the hospital would feature a nurse training corps. Many of the city's leading Black business and civic leaders led the project. Almost all served in leadership roles for the NAACP, the Federation of Civic Leagues, or both. Almost all participated in exclusive Creole social and pleasure organizations. Almost all sat on boards of Black life insurance companies. And, almost all favored accommodation over integration. They sought to create a separate Black institution.

"Help Yourself," urged advertisements for the hospital in the *Louisiana Weekly*. Writing in support of the hospital in October 1926, the newspaper urged all Black citizens to aid the project, following a model of self-help: "Let us evidence the spirit of independence. We should let the whole world see that we are determined to help ourselves in our affairs as far as human endeavor is possible."318

Initially, it appeared that the Colored Hospital Association would succeed this time. A fundraising drive commenced in October netted $40,000 dollars in its first week. All the local white newspapers gave "favorable editorial comments upon the movement," noted the *Weekly*, which also reported in September 1926 that "assurances have been given by leading white citizens that they will support the project with funds."319 Mayor O'Keefe endorsed the project, and promised to pave the roads—most of the Black neighborhoods in Central City still had dirt roads—as soon as they constructed the

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319 "To Build a New Hospital," *Louisiana Weekly*, Sept. 25, 1926
"The sentiment in favor with New Orleans Colored Hospital is indeed strong among both races," reported the *Weekly*, including white physicians who supported the Black hospital "as one in the interest of scientific advancement."  

Despite this enthusiasm and seeming progress, the hospital encountered the same problems as the earlier attempts. While the Colored Hospital Association drew from the Black economic elite and solicited funding from supposed white business allies, the "assured" financial support from whites never materialized. Without this contribution or the support of a large philanthropic organization that helped finance many Black hospitals—including Flint Goodridge—the effort collapsed, and in 1928 the Colored Hospital Association pledged instead to give their money raised to support Flint Goodridge. This led to the end of the Colored Hospital Association. Black leaders focused on their third option: Expanding Flint Goodridge. Administrators initially sought to buy property adjacent or elsewhere in the medical district. However, like the opposition faced by Newman and part of the effort to evict African Americans from the medical district, white landowners refused to sell the land for the Black hospital. Faced with this obstacle, hospital leaders looked elsewhere, but again found their efforts limited. White property owners throughout the city refused to sell property. Additionally, administrators had to obtain permission from the all-white city council to build a hospital in any section of the city under the 1894 municipal ordinance.  

The heads of Flint Goodridge Hospital announced plans to construct a new hospital in October 1927. Having been unable to purchase property from adjacent white

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322 CCS 9594," Synopsis of Ordinances, Commission Council Series, CANOPL.
landowners and facing a constant threat of closure by city inspectors, Flint Goodridge became part of a larger transformation of racial space in the city. With the backing of both school's administrators, the AMA and MEC jointly announced a merger of Straight College and New Orleans University into a single school which would be named Dillard University. Leaders hoped the union would create "one of the greatest universities of its kind in the world," a leading and financially stable—both Straight and New Orleans University had been losing money for years—higher education institution for African Americans. As part of the merger, Flint Goodridge Hospital would be affiliated with Dillard. The institutions would move as well. New Orleans University—still downtown on Canal Street—and Straight—located uptown on St. Charles—would consolidate onto the proposed site of Dillard in the Gentilly neighborhood. Flint would relocate from the medical district to Central City, one block from the site of the proposed location of the Colored Hospital. By that period, Central City had the largest concentration of Black residents and by the 1920s, Central City had become the main hub for the African American working class. When freedpeople migrated to the city in the thousands in the years after the Civil War, many settled in the neighborhood, which was cheaper due to its status as part of the more flood-prone "backswamps."323 Into the early twentieth century, asphalt, gravel, and timber industries mixed with dairies like the Woodside Dairy—which occupied the land that administrators later purchased for Flint Goodridge Hospital—and Black residences.324 The area lagged behind other neighborhoods, with no paved streets, water, or sewage lines at the turn of the twentieth century.

White New Orleans did not oppose the move of the hospital to the neighborhood, and the land was significantly cheaper than property in the medical district. Placement in the Black area helped facilitate the approval of City Council, which granted permission and amended the residential zoning ordinance for the desired property on Louisiana Avenue. The city viewed the less desirable property in Central City as the perfect location for Black residents, meeting their desired goal of Black spatial containment. To facilitate this process, the city built the first Black school and only Black playground there in the early twentieth century, and steered Flint Goodridge there in the late 1920s. The City Council also approved this measure to continue the removal of the Black medical profession from the main medical district in the Tulane Gravier neighborhood. Flint Goodridge left that area in 1932, following the earlier closing of the Flint Medical College and Provident Sanitarium.

Although Flint Goodridge left the Medical District, and the proposed Colored Hospital never came to fruition, the relocation of Flint Goodridge Hospital fostered the creation of a secondary, alternate Black medical district in Central City. A cluster of medical practitioners already operated on or near Dryades Street, about a mile from the site of Flint. This grouping included five dentists, two pharmacies (seven others operated nearby), and five doctor's offices, located inside the pharmacies, as well as the Unity Industrial Life and the Eagle Life Insurance Company. Starting in the 1920s, the Unity Industrial hired Dr. Raleigh J. Coker to run a health clinic at their headquarters on Dryades to provide free services—primarily infant and maternal care, vaccinations, and

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325 "CCS 10014," Synopsis of Ordinances, Commission Council Series, CANOPL.
care for minor health problems—for any member of the Black community, hoping to attract more subscribers.326

### Flint Goodridge's Many Initial Challenges

Finding a location for a new hospital proved to be only the first obstacle for Flint Goodridge leaders. The hospital needed to raise hundreds of thousands of dollars. This was a monumental task for an institution that had relied primarily on several thousand dollars a year from the MEC to supplement patient fees and one that struggled throughout its first decades to remain financially solvent. Hospital leaders worked with the Community Chest to form a fundraising campaign to raise a total of $2 million, with $1.5 million going towards Dillard and $500,000 dollars for the hospital. Volunteers solicited the money from 1929-1930. The Board of Education of the MEC and the American Missionary Association each pledged $500,000, and leaders secured an additional $500,000 from the Rockefeller Foundation and $250,000 from the Rosenwald Fund, which had recently decided to expand its philanthropy beyond education to reach to Black health care. The latter two groups stipulated that they would only donate the money if locals raised an additional $250,000. Fundraising leaders set a target goal of $200,000 for whites, and $50,000 for Black residents.327 More than twelve hundred Black residents donated, but campaign workers struggled to meet the $50,000 goal due to the

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poor economic situation of most Black New Orleanians. On the other hand, white New Orleanians surpassed their quota of $250,000, with no less than 3,000 residents giving a total of $328,000 dollars. For some whites, an altruistic desire to donate to support public health efforts and a general interest in equality may have motivated giving. White and Black leaders of the hospital publicly expressed this sentiment. Flint Superintendent H.W. Knight wrote that with the funding "the white men of the city have expressed themselves as understanding the colored man and liking him." Head of the Rosenwald Fund, Edwin Embree stated that "a new record was set for any southern city both in the sums involved and in the spirit of partnership between the races working for a common civic purpose." The NAACP's Crisis commented on the "genius" of the hospital

is not that of doing something 'for Negroes," out of the white man's wisdom and abundance. Instead, it is that of pooling the resources and the intelligence of both groups in a great community enterprise for the advantage of both—a policy that evidences a breadth of mind, of sympathy, and of cooperation that would be a credit to any community. Yet, despite these celebrations of interracial cooperation, three other less altruistic concerns appear to have been the primary causes of white support: fear of disease, a desire to have healthy workers, and the push for residential segregation and spatial concentration of African Americans in Central City. Fundraising leaders repeatedly emphasized the first concern in their quest to garner white support. Fundraising material prominently featured the phrase "The Microbe Knows No Color Line!" A 1929 report put out by the hospital to support fundraising emphasized the "proximity" of Black health

hazards to whites, due to the "constant contact of both races, by reasons of locality, employment, transportation, and recreation."

Speaking at a dedication of the hospital's new site in October 1929, Dr. W. W. Alexander—president of the newly created Dillard—told the assembled crowd: "The two races cannot be considered apart from each other in their problems, whether health or economics. If there is an epidemic among negroes, there will be an epidemic among the whites." This fear prompted white support of the new Black hospital, and was seen as a means of protecting themselves while not having to use or integrate white hospitals to deal with Black public health problems.330

Connected to this idea was the need to have a healthy Black labor force. Namesake of the university, Dr. James Hardy Dillard argued: "In improving the health of the negro, the white people are protecting themselves since negroes are necessary to the community and must be taken care of properly if local industries are to prosper."331

White leaders, including the mayor and city council members, encouraged white donations to facilitate the relocation of the Black hospital and the affiliated Black schools out of the neighborhoods deemed "white spaces." Speaking to a crowd in 1930, Mayor T. Semmes Walmsley told the white audience that "it was worth the entire amount asked to get the race schools off the sites they occupy." City councilmen too pushed for the plan, including attempts to assuage white residents of the Gentilly neighborhood who protested at a December 1930 city council meeting that locating Dillard University nearby would depreciate their property values and that the school would "form the nucleus of a Negro

colony." Whatever the motivation, white residents responded by giving $328,000 for Flint, far exceeding the quota.  

With funding secured, contractors built the hospital after breaking ground in 1920. In January 1932, 20,000 people attended an opening ceremony for the hospital. Designed by modernist architect Moise H. Goldstein, the four-story brick and stone hospital, "combined permanence and utility with exceptional beauty and good taste" noted *The Crisis*. The total cost for the property, building, and equipment came to $435,000 dollars, less than the projected $500,000 dollars, in sharp contrast to Charity hospital's $4 million dollars overage.  

Advocates of the hospital saw it as a significant milestone not only for Black New Orleanians, but for African Americans throughout the Deep South also. There were no Black-operated hospital in the region, and Flint Goodridge was still the only hospital with Black physicians. Philanthropist and Sears retailer Rosenwald described the venture as "one of the most epoch-making steps in behalf of the Negro since Lincoln's Emancipation." His right-hand advisor Embree spoke of the institution becoming one of the "Big Four" of Black hospitals in the country, joining Provident Hospital in Chicago, Provident Hospital in Baltimore, and Frederick Douglass Memorial Hospital in Philadelphia.  

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333 Flint Goodridge Hospital, *Health Hazards of New Orleans (1929)*, CANOPL.

334 Eleazer, "Flint Goodridge Hospital," 151.

The three hospitals that Embree cited shared many similarities with Flint Goodridge. All had been founded in the 1890s: Provident Hospital in Chicago in 1891, Provident Hospital in Baltimore in 1894, and Frederick Douglass Memorial Hospital in 1895. All three included in their mission statements three primary goals: care for Black patients, providing hospital opportunities for Black physicians not available in other hospitals in the city, and offering training for Black nurses. All three started as small, private hospitals in buildings in Black neighborhoods, relied primarily in their early years on donations from the Black community (particularly Black churches and fraternal associations), used women's auxiliaries to lead fundraising drives, turned to white civic and business leaders in support of fundraising, treated a small number of white patients, struggled financially due to providing reduced or free care to the low-income Black patients that were the majority of admissions, and repeatedly sought to expand and moved into a succession of buildings in their early decades. Two of the three entered into partnerships with white medical schools: Provident Hospital in Chicago with the University of Chicago, and the Provident Hospital in Baltimore with Johns Hopkins University and the University of Maryland. With these relationships and ensuing financial support, the universities gained positions of oversight on their governing boards. By the 1920s, these partnerships and financial support from philanthropic groups like the Rosenwald Fund and the Rockefeller Foundation brought financial stability to the hospitals. In contrast, Dr. Nathan Mossell, the founder of Frederick Douglass Hospital, refused to enter into a contract with the University of Pennsylvania, despite his status as a graduate of the medical school. In response, the state legislature ended annual appropriations to the hospital. Out of the three, Frederick Douglass Memorial Hospital
was the most financially unstable due to its lack of wealthy benefactors, and repeatedly lost accreditation in the 1920s.\(^{336}\)

Flint Goodridge followed the path of the Provident Hospitals in securing financial support from philanthropic groups, and an affiliation with a university (although it was the only one of the four hospitals to affiliate with a Black medical school). With a location found and money raised, the administration turned to what would become the controversial task of staffing the hospital. With the previous protests centered on having only white administrators and allegations of discrimination against those administrators still fresh, the new board of directors—headed by Dillard University President W.W. Alexander and Edgar Stern of the Rosenwald Fund—chose Albert W. Dent to become the new hospital's first Black head. Dent previously worked in accounting and fundraising in life insurance and higher education, and he was considered a brilliant administrative mind even at the age of 27. Alexander successfully recruited Dent, who was also considering a similar position with a Black hospital in Chicago and a posting with the Public Works Administration's new housing program.\(^{337}\) Dent and others on the board then focused on hiring the physician staff. The administrators quickly realized the dearth of Black physicians in the city. In 1932, only 35 registered doctors practiced in New Orleans.

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\(^{337}\) For more on Dent, see Joe M. Richardson, "Albert W. Dent: A Black New Orleans Hospital and University Administrator," *Louisiana History: The Journal of the Louisiana Historical Association* 37, no. 3 (Summer, 1996), 309-323.
which equaled one for every 3,704 Black residents. The closure of the Flint Medical College, the lack of professional opportunities, and exclusion from the Orleans Parish Medical Society prevented Black doctors from enrolling in post-graduate training or even using the medical library. Only two of the physicians in the city had completed internships; overall, just forty internships existed nationwide for Black physicians. The hospital hired 33 of the 35 Black physicians in New Orleans, but they needed more to fully staff the institution. As a result, the administrators made the controversial decision to name white doctors as heads of six of the seven departments, with Black physicians as associate heads. Dr. Rivers Frederick led the surgery department. The Board also continued the practice of allowing white doctors to treat their Black patients at the hospital.

Some praised the use of an interracial staff. The Crisis described the program as a "notable example of interracial cooperation." Other Black hospitals—notably Provident Hospital in Chicago and Provident Hospital in Baltimore—also used interracial staffs. Yet, others assailed the lack of Black leadership positions at the hospital. The Chicago Defender criticized the move, and contrasted it with the Colored Hospital Association's earlier plan to only have Black doctors on the full-time staff, with white doctors as consultants. "To the layman," the newspaper wrote, "it is easily apparent if Race men are excluded from serving as chiefs, one of the prime needs of the hospital is nullified." The article continued, "the biggest function of the Race in the new hospital would be to supply patients to the Race institution, heralded at the time of the drive for funds for it as the salvation of the Race physicians in this section of the South." The newspaper further

338 “Will W. Alexander to W.W. Brierley," July 7, 1932, American Missionary Association Collection, ARC.
speculated that the lack of Black leadership at the hospital may have led to Black residents declining to contribute to the fundraising drive. The criticism of white supervisors also came from groups like the NAACP, which expanded its condemnation to creating a separate Black hospital in the first place. In 1899, W.E.B. DuBois noted in his work *The Philadelphia Negro* that many Black leaders condemned Frederick Douglass Memorial Hospital as a "concession to prejudice and drawing of the color line." In 1931, the Board of Directors of the national NAACP passed a resolution condemning the actions of the Rosenwald Fund—especially the creation of separate Black hospitals like Flint Goodridge—as propagating segregation. In response, Embree argued the necessity of institutions like Flint Goodridge, and he pointed to the fact that only ten Black hospitals in the entire country were approved by the American Medical Association and American College of Surgeons to have Black patients and train Black physicians and nurses. While proponents held up Flint Goodridge and other Black-operated hospitals as vital to the African American community, debate about and criticism of separate Black hospitals like Flint would continue until the push for integration in the 1960s.

**A Black Health Center**

Dent and the other leaders of Flint Goodridge envisioned a new role for the hospital, one that matched the ideals first imagined when New Orleans University attempted to establish New Orleans as a medical hub centered around their planned medical school in the late nineteenth century. In 1929, the same year that C.C. Bass gave

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his speech predicting New Orleans as a "Medical Center" with Tulane's medical school as the key institution, Flint Goodridge released a booklet to support the fundraising effort that proclaimed their dream of New Orleans as "one of the five great health and education centers for colored people in the United States."^{342} Under Dent, Flint Goodridge would embrace this expanded role and join other Black hospital movement leaders who saw improved health as an important part of the larger "racial uplift" principle popular in the era.^{343}

The 1929 booklet addressed the major health issues that Flint Goodridge and Black health activists would have to address in New Orleans, where African Americans had a death rate more than twice as high as whites (28.1 per 1,000 compared to 13.7 per 1,000 respectively). The number of African American deaths in 1929 exceeded the amount of births, meaning that if not for migration from outside the city, the Black population would have declined. The researchers found that the Black mortality rate was the highest among the eleven cities with the largest African American populations in the country. The report identified several major causes: maternal/infant death rate, with 76.7 still births for every 1,000 births, 16.5 maternal deaths per 1,000, and an infant mortality rate of 12% (compared to white rates of 44.5, 11 per 1,000, and 5.9% respectively); heart disease (762 per 100,000 vs. 382 for whites); tuberculosis (310 vs. 101); pneumonia (288 vs. 46); and cancer.^{344}

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^{342} Flint Goodridge Hospital, "Health Hazards of New Orleans" (1929), Hospitals Subject Files, CANOPL.
^{343} Gamble, A Place for Ourselves, 109.
^{344} Flint Goodridge Hospital, "Health Hazards of New Orleans" (1929), Hospitals Subject Files, CANOPL
Dent and succeeding administrators at Flint focused on what they identified as the "three main health liabilities of the Negro": tuberculosis, maternal/infant health, and syphilis. To address these issues, Dent secured outside funding to create outpatient clinics specializing in all three problems by 1936. For the tuberculosis clinic, the hospital partnered with the Tuberculosis and Public Health Association of Louisiana, the Tuberculosis Committee of New Orleans, the Rosenwald Fund, and later the State Department of Health. The clinic conducted studies on incidences of tuberculosis, tested all babies seen at the hospital, all Black schoolchildren, and all patients at any of the hospital's clinics. The resulted in the testing of nearly 6,000 people in 1936 alone. They were also able to give free treatment for the indigent and they provided free bi-weekly lectures and demonstrations for any Black doctor within a 150-mile radius, in addition to free testing and treatment consultation for any of their patients testing positive. The tuberculosis clinic was the first in the city to offer the cutting-edge pneumothorax treatment. The hospital operated a syphilis clinic with the same set-up, including the free lectures and testing.

With the infant and maternal health clinic, Dent hope to reduce the number of women who used midwives instead of delivering babies in hospitals—21.7% of Black New Orleanians and 89.9% of Black Louisianans living in rural areas outside of the city used midwives. Dent hired a social worker to form mothers' clubs and teach prenatal and infant care and about "the inadvisability of trafficking with midwives." After determining

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346 A.W. Dent, "The Role of a Negro Clinic in the Control of Tuberculosis in a Large Southern City," Transactions of the Thirty-Seventh Annual Meeting of the National Tuberculosis Association (1941). AMA Addendum Series A Subseries Dillard, Records of Flint Goodridge Hospital, ARC.
that most of these women used midwives because they were cheaper than hospital services, which usually charged a $10-20 fee, Dent determined a $10 flat fee for having a birth at Flint Goodridge. As a result, births at the hospital increased 400% between 1932 and 1938, and by 1939 more whites used midwives than African Americans. The hospital also started "well-baby" clinics—with 1,242 visits in 1932 and 4,385 in 1938—and pediatrics clinics, as well as providing periodic free diphtheria immunization and whooping cough clinics.347

Clinics provided much needed treatment not only in addressing the major public health issues like tuberculosis and syphilis, but also in more standard care that most Black residents could not typically afford. For example, hospital clinics held a "Sight Saving Week" during October 1936, offering free services for those earning less than $75 a month. Of 700 patients that came for exams, doctors found eye defects and diseased

347 Perry and Perry, "Penny a Day Hospital." This problem presented a controversial issue for Dent. Black women made up the majority of midwives, and Dent did not want to directly attack the practitioners who were esteemed in the Black community, but often denounced by physicians. In an effort to professionalize midwives, Dent successfully lobbied for funding to start a graduate midwife program at Flint, but it only lasted one year and produced just two graduates. Hine, Black Women in White, 73. In the early twentieth century as specialization of physicians increased, the number of specialists in obstetrics-gynecology increased. As this field grew, these specialists—the majority of whom were white men—publicly attacked midwives as ignorant and backwards. By the second half of the twentieth century, the number of midwives shrank dramatically, disproportionately eliminating Black women from the field of childbirth. For more, see Keisha La’Nesha Goode, " Birthing, Blackness, and the Body: Black Midwives and Experiential Continuities of Institutional Racism" (PhD diss., CUNY, 2014); Jenny M. Luke Delivered by Midwives: African American Midwifery in the Twentieth Century South (Jackson: University Press of Mississippi, 2018); and Dorothy Roberts, Killing the Black Body: Race, Reproduction, and the Meaning of Liberty (New York: Vintage, 1997).
tonsils in half, and diseased teeth in a quarter. By 1939, the hospital added clinics for gynecology, urology, ear, nose, and throat; diabetes, and dental care.\textsuperscript{348}

Through the clinics and other services, the hospital found its original mission shifting. The founders in the 1890s created the hospital primarily to provide care for patients who could afford to pay for services, and thus were ineligible for treatment at Charity Hospital, with 20% of beds set aside for free services for the indigent. However, the health needs of low-income Black residents pushed the hospital to expand these services; by the late 1920s, one out of every three patients received free care. When administrators envisioned the new hospital in 1929, they planned to reduce the percentage of free care back to the planned 20% level. However, the new hospital opened as the Great Depression gripped the country, with African Americans disproportionately impacted, causing higher rates of unemployment and poverty than for whites. While African Americans made up fewer than 31% of households in New Orleans in 1935, they comprised 50% of all the unemployed and 65% of the families on federal relief. In New Orleans, as in many Southern locations, whites received preferential treatment for relief and re-employment programs, especially in the early 1930s; domestics or unskilled laborers, many African Americans were exempted from the National Relief Administration and minimum wage regulations. They often did not meet the minimum income for public housing. These conditions severely impacted the new hospital in two ways: the conditions of the Great Depression exacerbated health problems for many African Americans by increasing the number of patients in general and making the public health initiatives more difficult, and more needed; and these conditions pushed more

\textsuperscript{348} Perry and Perry, "Penny a Day Hospital."
Black New Orleanians into poverty, adding to the number of free patients. 349 Flint cared for nearly 46% of patients who paid no money for services at the hospital during the first year. By 1935, that number climbed to nearly 59%, and 11% of patients received reduced fee care. While the hospital served more patients overall, seeing an increase from 2,098 patients in 1932 to 5,719 in 1936, the high percentage of partial-pay and free patients kept income low. The outpatient clinics experienced a similar pattern. In 1932, 7,790 patients used the clinics, with 41.4% receiving free care. By 1935, the number reached 21,084, with 81% receiving free care. Additionally, many Black patients chose to transfer their services to Flint Goodridge from Charity due to poor treatment, which further expanded the free care. 350

More patients came to Flint Goodridge with the implementation of their hospital insurance program, a concept designed to increase working-class access. In 1935, Dent started a Penny-A-Day hospital insurance program, allowing patients up to twenty-one days a year in the hospital for $3.65 dollars a year. By 1938, over 3,200 people had enrolled. The American Medical Association endorsed the plan and identified it as the cheapest in the nation. In September 1939, Life Magazine ran a feature story on the program, citing it as the best hospital insurance plan in the country, and praising it as needed inspiration during the Great Depression and Jim Crow: "Frankly this is a success story; one that makes a heartening comment on democracy, in these dark days of race hatred and persecution. It is one of those things, we think, that makes you genuinely

happy to belong to the human race." The *Weekly* in 1936, described the Penny a Day Insurance plan and other programs as strengthening the hospital's "position in the community where its desire to operate as a Health Center and not merely as a hospital has long been recognized."

However, even with the income from the Penny a Day program, the hospital struggled to remain financially solvent due to the high number of non-paying patients, and they were forced to rely on fundraisers by the hospital's Women's Auxiliary, and sources like the Community Chest and the Rosenwald Fund to pay for the indigent services. Donations to the Community Chest remained low due to the Great Depression, and the organization distributed money to numerous other causes; funding from the Chest—raised throughout the 1930s primarily from whites using the repeated slogan "the microbe knows no color line"—stayed at $12,000 dollars a year. The Rosenwald Fund proved a much more reliable source throughout the decade. Son-in-law to Julius Rosenwald and a New Orleanian, Edgar Stern proved a valuable ally, serving on Flint's board of management and continually approving increased funding. However, the Fund ran out of money in 1943, and other ways to support the hospital needed to emerge. Although the city appropriated money to private, all-white hospitals, they regularly turned down Flint's requests. For example, in 1936, the city gave $30,000 to five white health institutions, but denied Flint's request for $3,000 "on the grounds that it was not possible to add any new appropriations to the City Budget this year."

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351 Perry and Perry, "Penny a Day Hospital."
353 "Superintendent's Report 1944," AMA Addendum Series A Subseries, ARC.
Patient numbers, and corresponding fees, increased steadily nearly every year. However, more patients led to the need for more personnel. Additionally, equipment replacement proved continuous and costly and was exacerbated by uncollected patient debts and threatened loss of accreditation. These problems would plague the hospital throughout its existence. Despite these difficulties, Dent and the hospital leaders sought to increase the hospital's impact, including efforts to improve Black medical education. Dent planned to restart Flint's medical school, although that never occurred. Dent began an internship program to help address the lack of internships available nationwide to new Black doctors, and created a post-graduate training program. Dent started the latter program in response to the exclusion of Black physicians from local American Medical Association chapters, which meant that not only were they not allowed to work in white hospitals, but that they were also denied post graduate opportunities provided by the AMA. To counter this, Dent opened an annual two-week program post-graduate program, featuring leading Black and white medical educators (primarily from Tulane University and LSU) and physicians from throughout the city, and offered it free for any Black physician in the country. From 1936 to 1940, the course had 207 participants from ten states. Over 33% of the Black physicians in Louisiana and 20% of Black physicians in adjoining states attended. The Rosenwald Fund also gave funding to support Black physicians at Flint doing post-graduate fellowships at hospitals throughout the country and internationally to further their training.\footnote{Dent, "The Role of a Negro Clinic."}

While these programs significantly helped the Black medical profession, attracting Black staff proved a persistent problem. With Howard and Meharry still the
only Black medical schools in operation, and the impact of the Great Depression further limiting the financial abilities of African Americans to afford attending medical school, the number of Black physicians had declined nationwide by the 1930s. With the opening of the new Flint Goodridge and its programs like the post-graduate seminar, the number of Black physicians increased from 35 in 1932 to 45 by the end of the decade, but the hospital still relied heavily on white physicians.

Additionally, the hospital's nurse training program, the only one for Black nurses in the state, was not producing enough graduates to meet the expanded hospital’s needs. In 1932, representatives from the Louisiana Board of Nurse Examiners, the National League of Nursing Education, and the National Organization for Public Health nursing reviewed Flint Goodridge's nursing program on Albert Dent's request as he sought accreditation. The representatives reported that the number of instructors, hospital's facilities, and number of patients were inadequate enough for accreditation, and in 1934 the nurse training program ceased. Dent pushed unsuccessfully for eight years to reopen the program. Instead, the hospital hired black graduate nurses from existing programs outside of Louisiana like Spelman College, but nursing numbers remained persistently low.356

"Slum" Clearance in Central City

Guided by Dent's vision of Flint Goodridge as the focal point for a health center for African Americans in the region, administrators early on planned to expand the hospital as its patients and services increased. However, federally funded, municipal action would forever alter this vision and hamper not just the growth of Flint Goodridge

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but the Black Medical District also. In 1937, the year state and local officials began displacing hundreds of Black residents to build the new Charity Hospital through PWA funding, the city applied for additional PWA funding to build separate Black and white public housing units. Inspired by state-sponsored housing in Europe, advocates successfully included housing as one of the PWA's authorized goals, and guided the building of early Modern Housing, communitarian-modeled units like the Carl Mackley Houses in Philadelphia (1935), which included a kindergarten and cultural center. However, conservative legislators used amendments to the 1937 Wagner Act to limit the radical nature of government-subsidized housing. The provisions required slum clearance to precede the building of housing, limited the amount that could be spent on construction (lowering the building quality), set caps on tenant incomes, and gave greater control to local governments over the projects.\(^{357}\)

Initially, Black leaders, including Flint's administrators, supported the application for a Black public housing complex. The *Weekly* reported that African Americans "joyfully received the news." The newspaper connected the issue of housing to health, noting that poor housing conditions contributed to the "disease epidemics," with the "homes of the wealthy whites being no forbidden grounds" due to their reliance on Black domestic workers. The paper sought through "slum clearance" the eradication of "dilapidated, unsanitary, 'revenue' houses" and replacement with public housing.\(^{358}\)

However, only months later, Black leaders changed their position when the city announced that it intended to use the PWA funding to clear the blocks surrounding Flint

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Goodridge Hospital as the intended site for the federal housing units. In an editorial titled "Not the Proper Location," critics decried the location: "If there was ever territory which needed slum clearance less than that adjoining Louisiana Avenue," the article argued, "we have yet to discover it in this city." Opponents noted that the city relied upon a study conducted in the early 1930s by white Tulane University students—"we can think of no group more ill-suited to the task"—with no updates or input from case workers from the Department of Public Welfare or Black leaders. Working class Black residents largely comprised the Central City neighborhood around the hospital. Over the objection of Black leaders, the clearance went forward.359

Several significant results followed the clearance. First, the C.J. Peete Projects, finished in 1941 and expanded for an additional six blocks in 1955, boxed in the hospital, curtailing future expansion. Second, while many envisioned public housing as a means to help improve the lives of lower-income individuals, potentially leading them to future home-ownership, due to the Wagner Act provisions, the government used cheap, low quality material to build the units. Rather than living in improved housing conditions, residents often found themselves trapped in quickly deteriorating and drab units, isolated and exposed to health issues—including lead poisoning. This would lead to an increase in the number of indigent patients using the hospital, and stigmatize the institution for its association with the projects and the neighborhood, which increasingly acquired a reputation for crime and drugs. The Weekly prophetically lamented the fate of the displaced working-class families, who would be pushed "to the farther reaches of the city, beyond the care of agencies which know and now meet their needs." For these residents

forced to move, the agencies included Flint Goodridge Hospital. As a consequence, many would have practically no access to health care until integration.\footnote{360 "Opposed to Proposed Site," \textit{Louisiana Weekly}, Feb. 26, 1938.}

The use of federal funding for projects in the 1930s in the two medical districts, the white one in the Tulane Gravier neighborhood and the Black one in Central City, demonstrated the power of federal laws and money in supporting local apartheid health care systems. Starting in the 1910s, the federal government primarily through the Public Health Services, and later with the National Institute of Health (created in 1930), began awarding research grants to universities and university-affiliated hospitals for research on public health issues and new treatments. Under New Deal programs like the PWA and WPA, the federal government started in the 1930s to fund the expansion of hospitals nationwide. Both of these sources helped lay the groundwork for the postwar period of the growth of the medical-industrial complex, with increasing number of hospitals and physicians, supported by increasing federal government funding. Tulane University—initially through grants to its School of Tropic Medicine and Hygiene—and the LSU School of Medicine received federal research grants that supported their growth in the pre-World War II period. Similar to the PWA-sponsored "slum" clearance and building of the new Charity Hospital in the 1930s, federal funding helped support their physical expansion in the Tulane Gravier neighborhood, and their student body, by increasing the schools' revenue. With an expanded Charity Hospital, Tulane and LSU—which each ran one of the wings in the hospitals—had increased opportunities for conducting research and more spots for students to train in the hospital. The physical presence of the three institutions in the form of Charity Hospital—the nation's second largest hospital and the
largest and most expensive WPA-sponsored hospital project—and Tulane University's Medical School—housed in the Hutchinson Memorial Building adjacent to Charity and connected to the hospital by an underground tunnel completed with WPA funding in 1937—and the LSU School of Medicine—located next to Charity—on blocks that used to contain Black homes and businesses attested to the power federal government funding for apartheid medical institutions.

In contrast, Flint Goodridge did not receive federal research grants. Due to the forced closure of Flint Medical College, the inability of Dillard University to start their own medical program, and the refusal of Tulane and LSU to affiliate with the hospital, the hospital was not a university hospital, and thus largely ineligible for federal research grants. Additionally, the municipal government used PWA money to prevent Flint Goodridge's expansion through its displacement of Black residents to build segregated public housing units. The use of federal funding to support the apartheid health care system would continue throughout the century.

**World War II and Postwar Problems**

World War II and the postwar period brought new obstacles for the hospital. In 1941, Albert Dent left his position at as the hospital's chief administrator to become the first Black president of Dillard University. He continued to play an active role with the hospital through his position as president and board member, but his direct daily running of the institution ceased. The hospital faced labor shortages during the war as many nurses and physicians joined the military. Dent helped address the dearth of nurses by successfully lobbying for financial support from the General Education Board, the Julius Rosenwald Fund, and the United States Public Health Service to start the state's a
collegiate-level nursing program at Dillard University, the third baccalaureate program in the country and the first at an HBCU. By 1948, the program produced 20 graduates, but only 7 worked at Flint Goodridge, hardly solving the nursing shortage which became exacerbated as many nurses left Flint Goodridge for paying work at Charity—which began using Black nurses due to their own shortages caused by the war—and hospitals outside of New Orleans.361

The double bind of racism and sexism also kept down the number of nurses. By this period, nursing had been gendered as women's work, and Black women in particular faced difficulties in becoming nurses. High levels of poverty, low levels of education, and gender-role expectations that women focus on the home sphere not only undermined Black women's ability to become physicians, but also decreased chances of admittance to the few nursing programs like Dillard that admitted African Americans. Additionally, southern states like Louisiana made Black women take separate nursing exams from whites, refused to permit needed training in hospitals, and denied them membership in professional organizations.362

Lacking nurses, in late 1945, Flint Goodridge closed 23 beds. The hospital hoped this to be temporary. To counter the loss, the hospital required employees to work longer hours, and offered slightly higher wages to attract more nurses after the war ended, but the beds remained closed for over two years.363

361 “Superintendent's Report 1944,” AMA Addendum Series A Subseries, ARC. For more on the nursing program at Dillard University, see Hine, Black Women in White, 77-83.
362 Hine, Black Women in White.
363 "Flint Goodridge Hospital: A Financial War Casualty," Press Release April 3, 1947, Flint Goodridge Hospital Collection, Dillard University (hereafter referred to as
The loss in beds led to a sharp decline in the hospital's revenue, exacerbating the continuing financial problems. In 1943, the Rosenwald Fund ceased. Fortunately, under Dent, Dillard assumed a large financial responsibility for the hospital, regularly paying off yearly deficits. The ending of the Rosenwald Fund forced the hospital to rely primarily upon patient fees. In 1932, 53% of the hospital's total income came from patient fees; by 1944, the year after the Rosenwald Fund ceased, this figure had climbed to 88% of the budget.\footnote{An increase in patient numbers and slight decline in free care occurred, reflecting the gradually improving economic condition of African Americans in the postwar boom period. However, the racist hierarchy limited these gains, as whites continued to discriminate against Black residents in hiring, promotions, and pay, leading to the perpetuation of higher Black rates of unemployment, underemployment, and poverty. Thus, Flint Goodridge's patient base never offered the stable support of the clientele at the private, all-white hospitals. Additionally, patient usage led to the need for more supplies, larger staff, and greater taxing of the already aging building and equipment. In his 1944 annual report, new Superintendent C.C. Weil noted the building and much of its equipment already needed costly renovations and replacement, a blood bank, and expanded laboratory facilities. The report also detailed that patients owed $12,407, in addition to an unspecified amount "believed to be uncollectable." The collection issue would be a continual problem for a hospital with a large majority of low-income patients. As a result, the hospital depended on fundraising by the Community Chest—which refused to raise annual allocations above $17,000—and supporters, both}

inside and outside of the city, not just of money but everyday supplies like linen and cutlery. This precarious reliance on an unstable funding base made the hospital's finances perpetually precarious. Inspecting the hospital in 1947, Dr. Basil MacLean—former superintendent of Touro Infirmary and an original Flint Goodridge board member—warned administrators they needed to "broaden" their financial support to "ensure survival."\(^{365}\) Even with increased use of the hospital, and a return to the target of 80% paying patients and 20% free patients with the postwar improved economy, financial instability (the hospital estimated that it spent $11.40 per patient day in 1949 and income per patient day only averaged $9.05 for the year) made annual survival challenging. Board member Edgar Stern estimated the costs for free patients exceeded funding from their donation bases by over $31,000 in 1952, and the hospital needed $60,000 for renovations and new equipment.\(^{366}\)

The need for equipment replacement and building renovation also reflected concerns over accreditation. Regular inspections by the Joint Commission of Hospital Accreditation; the American Medical Association; the American College of Surgeons; and state and local bodies like the Board of Health, forced the hospital to make improvements or face the loss of accreditation and forced closure, as occurred in 1914. In July 1954, the Joint Commission of Hospital Accreditation briefly stripped the hospital of accreditation. Although quickly restored after complying with their recommendations on

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"Superintendent's Report 1944," AMA Addendum Series A Subseries Dillard, ARC.
improved policies and equipment, the threat hung over the hospital for decades to come.\textsuperscript{367}

Another problem arose over hospital insurance, which white-owned companies refused to provide Flint Goodridge. As president of the Louisiana Life Insurance Company, Chief Surgeon Rivers Frederick directed his company in 1952 to draft a policy, but insurance coverage became an ongoing concern and an increasingly costly expenditure.\textsuperscript{368}

Attracting Black physicians remained an issue as well, following a nationwide decline in Black doctors in the 1930s and 1940s due to the closure of the Black medical schools and increasing poverty during the Great Depression. The inability to attend medical school in Louisiana, and the poor treatment of Black doctors in the Jim Crow city also lowered the number of available Black physicians for Flint Goodridge. Testifying before a House Committee on Interstate Commerce hearing on amendments to the Hospital Construction Act in May 1958, Flint Goodridge's Dr. William Adams informed the group of the exodus of Black physicians from the Crescent City in the postwar years, pushed out by segregation—including the refusal of the Orleans Medical Association to admit Black physicians and LSU and Tulane's excluding them from seminars and lectures—and pulled by greater professional opportunities and hopefully better treatment in the north and west. Adams told the committee: "Our younger persons have left the city and the state primarily to California and other places because of their refusal to stay in an atmosphere where their further study is hindered by discriminatory

\textsuperscript{367} "Study of Flint Goodridge Hospital" by Dr. F.C McLean & Dr. P.M. Murray Feb 15-17, 1955," Peter Marshall Murray Papers, Howard University.

\textsuperscript{368} "Letter A.W. Dent to Edgar Stern," January 2, 1952, FGHCDU.
laws." From a peak of 45 Black physicians in the mid 1930s, only 15 Black doctors practiced in New Orleans by the 1950s. This loss of physicians hurt Flint Goodridge's ability to maintain an adequate full-time hospital staff of doctors.\textsuperscript{369}

As a result, the hospital increasingly granted attending privileges to more and more white physicians who brought their paying Black patients to the hospital, but did not work full-time for Flint. Hospital Administrators argued that the interracial makeup of the staff served as a valuable counter to segregation, and Dr. MacLean told the \textit{Times Picayune} in 1947 that Flint's plan "has served as model" for other hospitals elsewhere. Regardless, the number of Black doctors working at the hospital and in New Orleans in general declined significantly after the war, rather than increasing as the hospital hoped.\textsuperscript{370}

Beyond Flint, the decline in number of physicians hurt the Black community in two main ways. First, with only 18 physicians for over 200,000 Black residents, visiting a doctor's office, or having them visit a patient at home, became even more difficult. Second, New Orleans lost many civic leaders. Flint Medical College had produced figures like Louis Martinet, the editor of \textit{The Crusader}, a leading newspaper advocating African American rights and a founding member of the Comites des Citoyens, which challenged segregation ordinances, resulting in the \textit{Plessy v. Ferguson} case; Dr. Ella T. Prescott, the first female doctor licensed by Louisiana; Dr. Aaron W. Brazier, president of the local NAACP chapter from 1937-38; and the afore-mentioned NAACP president Dr. George Lucas and vice-president Joseph A. Hardin. The civic community felt the


\textsuperscript{370} "Flint Goodridge Plan Acclaimed," \textit{Times Picayune}, April 15, 1947.
forced closure of Flint Medical College in the 1940s and 1950s. The retirements and
deaths—Joseph Hardin and Rivers Frederick both died in 1954—of physicians trained at
Flint Medical College left a void in leadership never quite filled by the limited number of
graduates of Meharry College and Howard University's medical school that came to New
Orleans.\textsuperscript{371}

Even with these physician losses, administrators increasingly recognized the need
to expand the hospital as the Black population continued to grow, reaching over 175,000
by 1950. Thousands visited the crowded clinics each year, reaching a peak of 32,274 in
1944, over four times the number of hospital's first year in 1932. Births increased ten-
fold, from 63 in 1932 to 631 in 1944. In the wake of criticism of the quality of care at the
hospital due to the above-described problems, Superintendent Weil launched a publicity
campaign in 1950 to highlight some of the hospital's improvements, including new
equipment, a blood bank, and cubicles in the wards to create privacy, and higher salaries
for nurses. Remarkable given its limitations and the poor health conditions of Black
residents, Flint Goodridge had the lowest death rate of any hospital in the city. The
hospital's maternity clinics and flat-rate birth plan had led to a dramatic drop in infant
mortality, from a rate of 119 per 1,000 in 1932 to 34.5 in 1952. Perhaps even more
astounding, in the first twenty years of the new hospital, 80\% of Black New Orleanians—

\textsuperscript{371} In 1947-1948, 495 there were 495 Black medical students in the South, all at
Howard and Meharry. In comparison, 8,608 white medical students were studying in the
south, with 953 in Louisiana. In the North, Midwest, and West in that same school year,
there were 93 Black medical students and 18,318 white medical students. Paul B.
Cornley, "Segregation and Discrimination in Medical Care in the United States," \textit{Journal
of the American Medical Association} 46 (1956): 1074-1081, 1077.
142,198 different individuals—used the hospital's services, averaging 4 visits per person for a total of 550,148 visits, and mothers birthed 6,740 babies.\(^{372}\)

The expanded Flint Goodridge struggled, especially financially, in its first two decades, but its accomplishments for the Black community were undeniable. The hospital had increased Black health care access, created hundreds of Black jobs, and addressed many of the Black public health issues. Change was coming, though, not just for Flint but for all health care institutions. In the 1950s, Black New Orleanians would increasingly push for the integration of health care. Chapter six will explore the Civil Rights struggle for equal access to health care.


Introduction

In 1953, Jessie Frohm took her son, aged 2 and afflicted cerebral palsy to Charity Hospital. A social worker at Charity referred Frohm to the state-funded Cerebral Palsy Center in New Orleans and they promised to schedule an appointment for her son. Frohm waited for weeks to hear back, and called repeatedly to find out when they would see her son. She finally secured an appointment in March. However, when she showed up for the visit, the administrator for the center informed her that "they didn't have any provisions for Colored." The woman, a Miss Rita, told Frohm that possibly in the future the center would offer one day a month for treating African Americans, but she did not know if or when that would happen. Frohm informed the social worker at Charity, who noted that the center repeatedly called her asking her to send over white children from Charity as the center had few patients. With few options, Frohm wrote to the local branch of the NAACP. Frohm pressed the organization to take on the issue and "see that facilities are provided for Negro children the same as for whites."³⁷³

Jessie Frohm's fight for her son was part of the decades-long struggle to desegregate health care in New Orleans, explored in this chapter. Starting in the late 1940s, African Americans dropped the push for enforcement of the "equal" part of "separate but equal," and increasingly pushed for the end of Jim Crow, including integration of the health care system. Sadly, Frohm's son would be a teenager by the time health services like the cerebral palsy center opened for African Americans in the 1960s.

³⁷³ "Statement of Jessie Frohm," August 6, 1953, NAACP Collection, UNO.
But the actions of his mother and others like her led to radical change in health care in New Orleans.

This chapter explores that period of health care Civil Rights activism. It examines a seemingly paradoxical problem with Flint Goodridge Hospital: the desire to expand the Black institution—thwarted for years by the state's denial of federal Hill-Burton funding—occurring as Black leaders pushed for access to all hospitals. This chapter details the new strategies employed by Civil Rights leaders like A.P. Tureaud, who turned to litigation to force desegregation of medical schools, and the impact of federal court decisions and legislation like the Civil Rights Act of 1964, Medicaid, and Medicare, which mandated integration of health care institutions. This chapter also details the concentrated efforts of Charity Hospital and private hospitals to defy integration, and the creation of "white flight" hospitals in the suburbs of New Orleans. As this chapter demonstrates, the late 1960s was another potential "crucial turning point" for the apartheid health care system, and white municipal and health care leaders fought to preserve the apartheid health care system.

**Flint Goodridge Hospital and Health Care Desegregation**

Flint Goodridge Hospital was both a vestige of earlier efforts to create separate Black spaces, and it was also at the forefront of the health care Civil Rights struggle. Leaders of the hospital pushed for desegregation of health care, even as they sought to maintain their growing institution. In the postwar period, patient numbers at Flint Goodridge continued to climb—more than 20% between 1949 to1954—even as the number of Black physicians in the city declined. The additional patients drove up income, allowing the hospital to withstand rising insurance costs, a burgeoning payroll for the 344
affiliated physicians and the 200 other employees that by 1959 accounted for 65% of the hospital's expenses, as well as needed improvements. In 1932, the hospital's budget came to less than $50,000 dollars per year; by 1959, the budget topped $750,000 dollars.374

With more income, and a growing number of patients each year, physical expansion seemed logical, but first the hospital needed to secure a funding base. In 1954, the newly formed Flint Goodridge Board of Management—which replaced a board of Dillard University administrators, and gave direct more control to the hospital—applied for federal Hill-Burton funding. The 1946 legislation made federal funding available—with the federal government providing 2/3 of the cost—for the expansion of existing hospitals and the construction of new ones, with the goal that each state would reach a quota of 4.5 beds available per 1,000 residents.375 From 1947 to 1971, the bill provided $3.7 billion in federal funding on 10,748 projects nationwide, creating nearly 500,000 new beds in medical facilities. Like other Black hospitals, Flint Goodridge faced difficulty in securing Hill-Burton funding. The legislation was supposed to determine funding based on a needs-based formula. Administrators would ascertain which area needed beds and then award funding to new hospitals or to existing hospitals for expansion. However, the Hill-Burton Act allowed hospital funding to be used for all-white or segregated hospitals, as long as some area facilities treated African Americans, and the number of beds for African Americans in the area matched the number of beds

374 "Growth Pamphlet," Rosa F. Keller Papers, CANOPL.
375 Known formally as the Hospital Survey and Construction, the legislation was the first part of a five-point plan presented by President Harry Truman to improve American health in November 1945. Truman noted that many hospitals nationwide were largely obsolete, and over 40% of counties in the U.S. had no hospitals. Senators Lester Hill (D, Alabama) and Harold Burton (R, Ohio) proposed the initial legislation to Congress, earning the Hill-Burton moniker.
for whites. Additionally, the individual states, not the federal government, would administer the funding. In the New Orleans area, Hill-Burton funding would aid the construction of nearly every new hospital in the city and in the suburbs, as well as the expansion of existing institutions over the following 25 years. Administrators disregarded the needs-based formula for African Americans and the requirement to make sure than an equal number of beds existed for Black residents as it did for whites.

In 1954, and for the following four years, the State Board of Hospitals denied Flint's request for Hill-Burton funding, stating they had already filled their bed quota for New Orleans. Instead, the Board allocated the funding for expansion of the all-white Touro Infirmary and the Children's Hospital, and it funded construction of the Ochsner Foundation Hospital. Ochsner was a five-story, 250 bed structure built in the Elmwood neighborhood. The state legislature denied Flint's requests throughout the decade, even though African Americans accounted for 97.6% of New Orleans's population growth between 1950 and 1958, meanwhile it approved funding for all-white hospitals.

The state finally approved Flint's funding in 1959. Flint Goodridge Board president Rosa Keller—a white socialite, Civil Rights activist, and heiress to the Coca Cola fortune—played a leading role in securing the funding. Edgar Stern asked her to serve as the chair of the new board of management, and Keller used her strong political connections to seek support for the hospital. After the state repeatedly turned down Flint's

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376 Sponsor Senator Lester Hill included the segregation language to win the support of other Southern senators for the bill.
378 "A Summary Statement on Inter-Group Racial Problems in New Orleans (A Plan for Dealing with them)," J. Harvey Kears Executive Director Urban League of Greater New Orleans, 1961, NAACP Collection, UNO.
Hill-Burton request, Keller and chief administrator C.C. Weil traveled to Washington to seek federal support from Department of Health, Education, and Welfare (HEW) officials. When the state still refused Flint's requests despite support from HEW, Keller arranged a personal meeting with Earl Long—he would only meet with Keller, not Weil who was Black—and he agreed to support the spending. With $500,000 dollars secured through Hill-Burton, the hospital launched a drive in 1958, headed by Keller, to raise an additional $450,000 from New Orleanians. Similar to the 1929-1930 campaign, prominent white citizens like Mayor DeLesseps Morrison encouraged white residents to support the drive. Keller sought his aid, and the mayor served on the campaign's Committee of Sponsors. Morrison and his aides directly contacted business leaders to solicit donations, and allowed the campaign to use utilize payroll deductions for city workers. Keller wrote to Morrison in April 1958 to thank him for his "invaluable assistance" and stating that "without your efforts our present status could not have been reached."

Akin to the earlier campaign to build the new Flint Goodridge in the late 1920s, Morrison appeared to be motivated to support the hospital to maintain Jim Crow. The Civil Rights struggle in New Orleans had intensified throughout the 1950s, achieving significant victories including the integration of colleges in 1953, desegregated transit in 1958 (an effort partially led by Dr. William Adams of Flint Goodridge Hospital), and successful boycotts of Dryades Street businesses that forced them to hire Black workers.

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380 "Rosa Keller to Mayor DeLesseps Morrison," April 30, 1958, DeLesseps S. Morrison Records, CANOPL.
employees. In response, Morrison and other prominent white city leaders, fought to maintain Jim Crow, especially after the Supreme Court's 1954 Brown v. Board of Education ruling led to a federal district court order to desegregate the Orleans Parish School system.\textsuperscript{381} In reaction, White Citizens Councils formed in the south, including a chapter that started in 1955 in New Orleans, to oppose integration through economic boycotts, protests, threats, and violence. This push for integration and civil rights, and violent backlash, created the context for Morrison's support of the hospital's campaign. Morrison strongly endorsed segregation, and it was his desire to keep the city's hospitals segregated that led to his involvement. Earlier actions foreshadowed this role. For example, Morrison bowed to pressure from Black leaders to support the creation of the Pontchartrain Park golf course after the NAACCP sued to desegregate City Park and Audubon Park golf courses. Morrison told white opponents of the proposed Black park in May 1950:

\begin{quote}

We have got to just make up our minds that if we are going to preserve traditions and habits of our city that we are going to have to provide facilities to meet the demands of the Negro people.\textsuperscript{382}
\end{quote}

Morrison continued to support the funding of separate Black facilities like recreation places, schools, and Flint Goodridge to prevent integration through the end of his term.

In addition to the specter of integration, the fear of the spread of disease played a significant role in garnering white contributions, as it did in 1929. Using the same kind of rhetoric as the earlier drive, the official campaign pamphlet warned that "civilization has progressed to the point where a city the size of New Orleans can be saved from disease

\textsuperscript{381} For more on the history of New Orleans's school system, see Walter Stern, Race and Education in New Orleans: Creating the Segregated City, 1764-1960 (Baton Rouge: Louisiana State University Press, 2018).

\textsuperscript{382} Haas, DeLesseps S. Morrison, 75-76.
by one inoculation, or blown into oblivion by one explosion." The document also emphasized the economic benefits of African American health. The pamphlet described the hospital as having "helped thousands of those employed by local industries to a healthier and more secure life, and therefore added to the economic wellbeing of the city."\textsuperscript{383}

These strategies worked, as white and Black residents gave over $450,000. In total, the campaign, federal funding, and philanthropic giving netted $1.36 million dollars, which was used to build a four-story addition in 1960. With the new wing, the hospital expanded its number of available beds from 88 to 128, and bassinets from 12 to 20.\textsuperscript{384} The following year, despite the addition of the new beds, the hospital reported a waiting list for patients.\textsuperscript{385} Thus, the hospital's new wing not only seemed prudent, but it was also as a harbinger of further expansion in the immediate future. With increased income, the financial troubles of the past appeared to be behind them, and the 1960s looked to be the most promising decade in the hospital's existence. With a new wing, Flint flourished in the early 1960s, witnessing steady growth in patient numbers. With 350 affiliated physicians and 220 full-time workers, Flint served as the largest Black employer in Louisiana. Continuing its mission of improving health care access and addressing public health issues, Flint helped reduce the Black mortality in the late 1960s to 10.06 per 1,000, nearly equal to the white rate of 9.15.\textsuperscript{386}

\begin{footnotesize}
\begin{enumerate}
\item\textsuperscript{383} "Expansion," Flint Goodrich Subject File, CANOPL.
\item\textsuperscript{384} "Memorandum Rosa Keller to All Workers in the Special Gifts Division," March 19, 1958, Mayor Chep Morrison Records, CANOPL.
\item\textsuperscript{385} "Minutes of the Board of Management," May 22, 1961, FGHCDU.
\item\textsuperscript{386} "Minutes of the Board of Management," January 26 1970, FGHCDU.
\end{enumerate}
\end{footnotesize}
Despite these accomplishments, Flint Goodridge found itself in a conundrum in the 1960s. Flint had accomplished much in previous decades for the Black community, although some Black leaders continued to criticize its very existence as a separate Black hospital as propagating health care segregation. Yet, even as they faced this criticism and continued to advocate for their institution's expansion, many associated with the hospital pushed for the end of apartheid health care, most visibly Keller, who used her social position and connections to seek out allies in the white community. Keller was part of a group from Flint that met with members of the Orleans Parish Medical Society about integrating the organization in 1954. The contingent argued that the denial of membership to Black physicians had helped drive Black doctors away from New Orleans and jeopardized the hospital's future. OPMS Hospital Committee Chairman Dr. C. Walter Mattingly told the Flint representatives that the OPMS would not integrate, and that Flint's real problems were inadequate facilities and "poor hospital administration."

Mattingly also argued that part of the reason that Black doctors left was because "the colored man wants a white doctor. How are you going to change this?" Mattingly informed the Flint contingent that integration "was not the solution to Flint Goodridge's immediate difficulties" and refused to support the idea.387

Undeterred, that same year Keller met with Ochsner founder Dr. Alton Ochsner to seek his support on integration and ask him to both serve on Flint's board and hopefully form a partnership between Flint and the Ochsner Foundation Hospital. Ochsner refused, and Keller noted that his "racist" behavior and hostility to Black medical professionals left her "terribly frightened." Similarly, when she met in 1959 with the heads of LSU's

387 "Orleans Parish Medical Society Minutes," Feb. 1, 1954. Orleans Parish Medical Society Collection, LRCTU.
medical school about allowing Black physicians to use LSU's library material and attend medical meetings, they rejected her requests and replied "I can't understand this [training Black doctors]. Why would a n****r want a n****r doctor anyway?"  

This exclusion from professional opportunities, combined with everyday harassment and discrimination of Jim Crow, was in large part responsible for this exodus of Black doctors from New Orleans. Dr. George Thomas recalled in a 1985 interview that he inherited his practice in New Orleans in 1947 after a fellow Black physician was arrested while driving home from a medical conference in Mississippi for "indecent behavior"—his crime was stopping by the side of the road to eat his lunch. Upon his release, he left the city because he was no longer willing to put up with the treatment.

This episode demonstrated the synchronicity between the apartheid health care system and the larger system of Jim Crow. The medical system helped uphold Jim Crow through its maintenance of the color line by excluding Black physicians and Black patients. Simultaneously, the larger system of Jim Crow limited the Black medical system, curtailing and driving away Black physicians, and preventing the growth of Black medical institutions like Flint Goodridge and Black medical practices.

In turn, white medical professionals used the health disparity caused by inadequate access to health care and the negative social determinants that resulted from Jim Crow to continue to justify Jim Crow, particularly as the Civil Rights Movement intensified. White proponents especially used higher Black disease rates as a main

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388 "Untitled Document," Rosa F. Keller Papers, CANOPL.
389 "Interview of George Thomas Jr.," Feb. 15, 1986, George Thomas, Jr. Papers, ARC.
argument against integrating the public school system. In November 1955, the Board of
Directors of the OPMS adopted the following resolution:

Whereas, the statistics of the Louisiana State Department of Health for the years 1950-54 for the Parish of Orleans and the State of Louisiana as a whole, indicate a tremendously greater incidence of venereal diseases and illegitimacy of births among the Negro race than the white race of school age; therefore be it,
Resolved, that the Orleans Parish Medical Society go on record as being of the opinion that it would be a distinct health hazard to integrate the races in the schools of Orleans Parish, as well as other Parishes of the State of Louisiana at this time.

The Board planned to have their resolution read as part of the parish school board's legal fight to prevent desegregation. At the suggestion of the Director of the Medical Department of the Public Schools, the school board's lawyer Joseph H. Rault alongside the leaders of the OPMS joined to "work on the health angle" of opposition. OPMS President Edgar Hull stated: "The propriety of the resolution is evident from Article I of our Charter, which states in part an object of the Society is the betterment of public health of the community." At an OPMS general meeting, over 150 voted on the resolution; OPMS bylaws required a unanimous vote on the measure as it had been introduced without an announcement at the previous meeting. With exactly one member—unfortunately not identified in the meeting minutes—voting in opposition, the resolution failed. 390 Although the OPMS general body never formally adopted the resolution, in 1956, the Orleans Parish School Board filed affidavits in a federal case over desegregation from eight white physicians and three psychiatrists who argued that

390 "OPMS Meeting Minutes," November 14th and 22nd, Orleans Parish Medical Society Collection, LRCTU.
integration of the schools would "confront the community with a health hazard" and would be "psychiatrically traumatizing to the children of both races."\(^{391}\)

White civic and political leaders like Leander Perez also used African American health statistics and the threat of disease as "scientific" evidence to oppose desegregation, much like the advocates of slavery and the authors of Jim Crow in earlier periods. Senator Allen J. Ellender told a Black reporter in support of his opposition to school desegregation in February 1955: "I do not particularly like to quote venereal disease statistics about any group, or to cite crime rates, but these are things we must recognize."\(^{392}\) That same year, in the immediate aftermath of *Brown v. Board*, the state legislature passed a bill that required segregated schools under the state's "police power" to maintain "public health, morals, better education, peace, and good order."\(^{393}\)

While proponents of maintaining segregation continued to use the rhetoric of poor African American health—often discussed as a sign of the physical inferiority and moral ineptitude—and the disease risk posed by integration, they both refused to discuss the root causes of the higher Black disease and mortality rate. They remained unwilling to use the white health care system to improve Black health. The Jim Crow system was largely responsible for the health disparity. The segregation of Charity and denial of admittance at private hospitals combined with many of issues that Civil Rights organizations fought against—white civilian violence; false arrests of African Americans in "white spaces" for disturbing the peace, vagrancy, and loitering; police brutality;

\(^{391}\) "Polls of New Orleans Doctors Challenges Statements that School Integration will be Psychiatically Dangerous," *Journal of the National Medical Association* 48, no. 5 (September 1956): 358.
\(^{393}\) Fairclough, *Race & Democracy*, 169.
employment discrimination; school segregation; and environmental racism—which had so severely damaged African American physical and mental health. For instance, the rate of tuberculosis—caused by factors like poor housing conditions and poor nutrition—was 107 per 100,000 for Black residents in 1947 compared to 53 per 100,000 whites. Thus, Jim Crow helped create a self-perpetuating cycle. Segregation caused higher Black disease and mortality rates, and whites used higher Black disease and mortality rates to justify segregation. Black New Orleans recognized the hypocrisy of this cycle. In a July 30, 1963 editorial in the *Louisiana Weekly* entitled "A Pattern of Gross Indifference," the newspaper criticized the city's neglect of Black health and its use as justification for Jim Crow:

> Arguing against desegregation of schools, public and private institutions, attorneys for the City of New Orleans have not hesitated to haul out morbidity reports to substantiate their claim that Negroes are the chief sufferers of various infectious and contagious diseases. Yet, the city itself is guilty of contributing to such a condition.

**Civil Rights and Health Care**

After World War II, Black New Orleanians began shifting their approach to problems like access to health care and those "patterns of gross indifference" the *Weekly* noted. In an earlier period, Black leaders in New Orleans continued to favor the accommodationist model, with an effort to push the city not to integrate but rather to uphold the "equal" part of "separate but equal." However, New Orleans and Louisiana politicians in no way made any pretense to maintain the "equal" part of "separate but equal" health care. The awarding of Hill-Burton funding to all-white hospitals over Flint Goodridge, despite the already higher number of beds for white residents, was just one

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394 "Field Training Report," March 24-May 29, 1947; Small Collections, ARC.
example. In medical education, although the state supported Southern University to maintain segregation in higher education—with LSU for white students and Southern for Black students—the state never appropriated enough funding to start a promised medical school for African Americans. Similarly, while Charity admitted African Americans into a short-staffed and underfunded segregated ward, the state failed to provide other needed medical services. In response, Black residents like the afore-mentioned Jessie Frohm pushed for access to health care, as patients and as workers. In April 1951, three women—Katherine London, Marie Williams, and Margarita Brown—attempted to enroll in Charity Hospital's nursing program. Told that the program was "not offered to the Colored because of the lack of sufficient facilities and housing," the women, like Frohm, brought the issue to the NAACP.

Through this activism, initiated largely by African American women seeking employment in the health care field, or access to health care for their families, health care became part of the larger Civil Rights struggle in New Orleans. Although it never received as much focus as other issues like housing, employment, or voting, these efforts led to complaints filed by the NAACP, and then litigation pushing for integration, starting with medical education, as new leadership in the NAACP increasingly adopted more direct challenges to Jim Crow.

In 1941, Dr. Lucas, Dr. Hardin, and other members of the city's Black economic elite that favored a more accommodationist lost power to a cadre that called themselves "The Group." Backed by a mass of mostly blue-collar workers—postal workers, truck drivers, and insurance salesmen—members of the "the Group" won leadership positions

396 "Statements by Katherine London, Marie Williams, and Marguirite Brown," April 9, 1951, NAACP Collection, UNO.
on the executive board of the New Orleans chapter of the NAACP.\textsuperscript{397} The new executive board members led by attorney A.P. Tureaud and Reverend A.L. Davis were younger and favored using the federal courts, including in health care challenges. In 1946, A.P. Tureaud filed a suit against LSU on behalf of Viola Davis, a Louisianan who had completed her first year as a medical student at Meharry College in Nashville, but wanted to transfer to LSU.\textsuperscript{398} Although Tureaud lost in the Davis case, he won three lawsuits against LSU between 1950 and 1952, which forced the school to admit African American students, including Daryle Foster, the head nurse at Flint, who enrolled in LSU's nursing program. With Foster's legal victory in March 1952, the judge imposed a permanent injunction against LSU barring Black applicants to its School of Medicine. However, despite this victory, and a similar 15-month court battle that forced Tulane to drop its whites only policy in 1963, administrators continued to deny every Black applicant at both schools as subjectively "unqualified." LSU would not admit their first Black medical student until 1965; and Tulane not until 1967.\textsuperscript{399}

\textsuperscript{397} For more on the "Group," see Sharlene Sinegal DeCuiur, "Attacking Jim Crow: Black Activism in New Orleans 1925-1941" (PhD diss., Louisiana State University, 2009).


Activists also used litigation to desegregate hospitals, although not until the 1960s; like the medical schools, hospitals would also delay integration despite court orders for years afterwards. Nationally, after years of lobbying and activism, the NAACP and the National Medical Association initiated their formal push for the end of segregation in hospitals in 1956.\footnote{A 1959 survey found that only 6\% of hospitals in the south were integrated; over 33\% admitted no Black patients at all, and the rest treated African American patients in segregated wards or sections. The survey also found only 25\% of southern hospitals granted staff privileges to African American doctors. "U.S. Hospitals and the Civil Rights Act of 1964," Hospitals and Health Networks Magazine, June 3, 2014.}\footnote{"U.S. Hospitals and the Civil Rights Act of 1964."} Founded in 1895, Black physicians formed the National Medical Association as a professional organization for Black physicians excluded from the American Medical Association. Focused initially on professional development, improving Black hospitals, and public health initiatives, in the 1950s, the NMA began pushing for integration of the AMA, medical and nursing schools, and hospitals. The NMA supported the NAACP’s desegregation lawsuits, including the 1956 lawsuit to end the separate but equal provision of the Hill-Burton Act. Although they lost their first cases, the organization continued to file suits in different states. In 1962, the NAACP filed suit in North Carolina in *Simkins vs. Moses H. Cone Memorial Hospital*. After losing at the district court level, they appealed, with the Supreme Court upholding a federal appeals court ruling striking down the separate but equal provision as unconstitutional in March 1964.\footnote{"U.S. Hospitals and the Civil Rights Act of 1964."}

While activists pursued these cases elsewhere, through early 1964, civil rights leaders in New Orleans continued to focus on other issues, eschewing hospital integration. Local groups filed lawsuits to integrate the schools, the municipal auditorium, public parks, and recreation facilities, but not hospitals. In February 1963,
Flint Goodridge's Board of Management discussed suing Charity to force them to hire Black physicians, despite this potentially further draining their own already limited doctor pool; ultimately, they did not pursue the lawsuit.\textsuperscript{402} In September 1963, over 10,000 New Orleanians participated in a Freedom March from Shakspeare Park in Central City to City Hall. The leaders of the event, the Citizens Committee of New Orleans, attempted to give Mayor Victor Schiro a "Petition to the Greater New Orleans Community." Schiro refused; instead, the group presented the document a week later to a meeting of the City Council. An initial draft of the petition demanded desegregation of hospitals—for both patients and staff—in the city as point nine. However, the final version only included the first seven points that addressed hiring of Black employees, repeal of city segregation ordinances, and integration of city properties; they dropped the request for hospital integration.\textsuperscript{403}

It was not until the Supreme Court's ruling in March 1964 that struck down the separate but equal provision of the Hill-Burton Act, and the Department of Health, Education, and Welfare's subsequent announcement that all hospitals receiving funding must desegregate or lose the Hill-Burton funding, that hospital desegregation efforts in New Orleans started. The week of the Supreme Court ruling, two Baton Rouge Hospitals—Our Lady of the Lake and the Baton Rouge General Hospital—announced they would allow Black physicians to treat their Black patients in the hospitals. However, New Orleans hospitals which had received Hill-Burton funding ignored the court ruling.

\textsuperscript{402} "Board of Management Minutes," Feb. 21, 1963, FGHCDU.
\textsuperscript{403} "Petition to the Greater New Orleans Community," (Undated), Ernest "Dutch" E. Morial Papers, ARC.
and HEW order. In response, New Orleans NAACP branch president Ernest Morial stated the organization had been "studying" litigation "for some time" and he anticipated that the branch "will take action in the future toward the full implementation of the supreme court's ruling."

Despite Morial's statement, litigation did not immediately occur. Again, this may have reflected the NAACP chapter's focus on other issues deemed more pressing. It also may have been the result of the decline in influence of Black physicians within the NAACCP and other civil rights groups. With the loss of power of the physician elites in 1941, the loss of Black physicians in the postwar period, and the death of prominent Black doctors like Joseph Hardin and Rivers Frederick, few of the city's less than twenty Black physicians played an active role in the leadership of Civil Rights organizations. Few Black doctors in New Orleans even publicly called for integration in hospitals. At their annual meeting in February 1963, National Medical Association President John A. Kennedy urged all members as "social engineers" to personally advocate for the desegregation of hospitals; this did not occur in New Orleans. An April 5, 1964 editorial in the *Weekly*, noted that Black physicians led the push to integrate the Baton Rouge hospitals, and chastised the public silence of Black doctors in New Orleans:

And it is indeed surprising to say the least that even at this late date there has been no voluntary public expression on the issue by Negro members of the local medical profession who have been hampered by racial discrimination even more-so than Negro patients…It is now discouraging that Negro doctors have given

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405 "Hospitals Using U.S. Funds Must Desegregate Says Court."
406 "NMA Doctors Urged to Support Cause, Fight Hospital Bias," *Louisiana Weekly* February 23, 1963. For more on the dangerous swimming and beach conditions, see Andrew Kahrl, *This Land was Ours: How Black Beaches Became White Wealth in the Coastal South* (Chapel Hill: University of North Carolina Press, 2012).
absolutely no public indication that they too will seek to implement the Simkins-Cone decision in the local hospitals which are now receiving or which have received Hill-Burton and other federal funds"

Instead, individual citizens, with support from the NAACP Legal Defense Fund pressed for hospital integration, an issue that was aided significantly by federal legislation, particularly the 1964 Civil Rights Act. Passed after years of Black advocacy—and over the opposition of all of Louisiana's white federal representatives—the Act contained Title VI which mandated that all hospitals desegregate and no longer discriminate, or be subject to the denial of all federal financial assistance.\footnote{407}

The same month that President Johnson signed the Civil Rights Act of 1964 into law, Callie Castle, the grandmother of leading civil rights activist Oretha Castle Haley, became the lead plaintiff in a class action lawsuit filed in federal court to desegregate Charity Hospital, claiming the continued segregation violated the equal protection clause, the Due Process Clause, and Title VI of the 1964 Civil Rights Act.\footnote{408} Facing the lawsuit, Charity slowly started to integrate. In October 1964, the hospital board voted to integrate the tuberculosis wards. That same month, Dr. Gilbert Tomsky, the chairman of the hospital's medical committee, said that Charity was 80% integrated and that the integration of the tuberculosis wards represented "one more step towards a gradual elimination of physical segregation in the hospital."\footnote{409} In January 1965, Charity announced that the "colored" and white signs had been completely removed.\footnote{410}

Louisiana continued to maintain segregation in other state-administered hospitals, including those in the Charity system. In June 1965, the Louisiana Civil Liberties Union

filed a lawsuit to desegregate the Washington-St. Tammany Hospital in Bogalusa, which was followed by a NAACP lawsuit against the Charity hospital in Alexandria. In December 1965, District Court Judge E. Gordon West ordered the desegregation of all state hospitals. State Hospital Director R.B. Walden stated that all hospitals would be able to comply by the end of the year and pledged that all personnel for state hospitals would be hired from the civil service list without racial discrimination. The ruling did not apply to Charity Hospital in New Orleans and Confederate Memorial Hospital in Shreveport, as they had their own boards; however, Walden falsely claimed that both hospitals had already completely desegregated.411

At the municipal level, the New Orleans Board of Health considered openly rejecting the federal non-discrimination order and accepting the loss of federal funding. Director of Health Rodney C. Jung wrote to Mayor Victor Schiro in February 1965 to ask if the Board should sign a required document pledging non-discrimination or decline all further federal funding. Schiro ultimately decided to order the document signed so as not to lose the needed revenue source.412

Despite these public announcements by health care leaders of compliance with desegregation, most medical institutions privately refused to integrate. In the following years, civil rights leaders in New Orleans and throughout the South fought a battle against this resistance by primarily relying on litigation, despite the lack of enforcement. Patients complained about being denied admission or the continuation of segregation to

412 A handwritten note on the back of the letter—either by Jung or Schiro—included the question "must we hire n-----s?" next to a picture of a rifle. "Letter Rodney C. Jung to Mayor Victor Schiro," February 9, 1965, New Orleans Health Department Collection, CANOPL.
the NAACP, which in turn forwarded the complaints to HEW. After HEW refused to enforce compliance, the NAACP Legal Defense and Education Fund filed federal lawsuits. Starting in February 1965, the NAACP sued dozens of hospitals, including New Orleans's Sara Mayo Hospital, which only treated Black patients in separate facilities and continued to refuse to hire Black doctors.413

Sara Mayo's administrators defended their hiring decisions by arguing that official hospital policy was to only hire physicians that were members of the Orleans Parish Medical Society, which maintained its white-only member requirement. By the mid 1950s, although a few scattered county medical societies in South Carolina, Tennessee, Texas, and Virginia refused admittance to Black members, most county medical societies and all state medical societies except for Louisiana and Mississippi admitted Black members.414 OPMS members brought up integration in the 1950s. In November 1956, members Dr. Harris and Dr. Ferris introduced a measure to drop the "white" requirement. The organization held a vote at their December 10th meeting. With a 107-88 vote in favor of dropping the white requirement, the measure failed the required 2/3 threshold to change membership policy.415 After the 1956 failed vote, the OPMS became more entrenched against integration, especially during the battle over school segregation in the late 1950s and early 1960s. In 1958, Flint Goodridge Hospital's Dr. William Adams

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414 However, every county level dental society continued to exclude Black members. Cornley, "Segregation and Discrimination in Medical Care in the United States," 1077.
415 "OPMS Meeting Minutes," Dec. 10, 1956, OPMS Collection, LRCTU.
testified before the House Committee on Interstate Commerce and informed them of the problem Black doctors faced due to exclusion from the medical society:

In New Orleans no Negro appointments are allowed on the hospital staffs either as interns, residents, or staffmen… We have considered the proposition of getting on the [hospital] staffs and participating in the work, we are always told that in order to become eligible for the staff you will have to join the parish society. Of course the society has a lockdown against Negroes. Thus you can't get into the society because you are a Negro and you can't get on the staff because you can't get into the society.

Because the state medical society and all the medical societies maintained their whites only membership clauses through the 1960s, before 1965 Black doctors in Louisiana could only serve on the staff of Flint Goodridge Hospital. Adams informed the members of the committee that he and other physicians and Civil Rights activists were planning to sue the OPMS and other parish medical societies that denied Black membership. Adams told the House Committee on Interstate Commerce that some doctors in northern Louisiana had initially opposed the effort, because they feared retaliation, particularly from the state, as the state had already denied reimbursement for providing care for indigent patients. Adams asked the committee for their guidance on whether they should initiate litigation; Congressional records do not document any response by committee members to this question, and no court records of such a lawsuit against medical societies in Louisiana have yet been found by this researcher. As the mother organization, the American Medical Association could have mandated that all state and county level AMA affiliates drop whites-only clauses. Despite more than a dozen proposals introduced from 1944 to 1965 by state-level AMA chapters, and continuous requests from the National Medical Association, it was not until 1966—after a publicized protest at the AMA's national meeting in New York City in 1965—that the AMA amended its bylaws to
investigate discrimination by local chapters and potentially strip them of affiliation.\textsuperscript{416}

The AMA's intransigence until that year gave medical societies in Louisiana carte blanche to continue their discrimination against Black doctors. Both the OPMS and the Louisiana State Medical Association refused to integrate until 1965, making the state the last one in the nation to integrate. Following the April 1965 lawsuit against Sara Mayo which highlighted their OPMS membership stipulation, at their May meeting, the OPMS finally voted to eliminate the word "white" from its bylaws, and in June admitted four Black physicians.\textsuperscript{417}

In July 1965, President Johnson signed into law Medicare and Medicaid. Implemented in Louisiana in July 1966, Medicare and Medicaid offered a stream of federal revenue to hospitals, provided they meet the requirements of the Civil Rights Act of 1964, and served as a further push for the integration of private hospitals. In private practices, many white physicians continued to refuse to treat Black patients or desegregate waiting rooms. In September 1965, State Welfare Commissioner Garland Bonin sent a letter to all doctors and dentists that the maintenance of segregated waiting rooms would prevent them from participating in the federal medical vendor program, a program administered by the state that provided funding for treating some low-income residents prior to Medicare and Medicaid's implementation. Those that wished to participate would have to sign a non-discrimination document; doctors who wished to keep segregated waiting rooms could opt out of the program. Bonin noted his personal

\textsuperscript{416} For more, see Harriet A. Washington; Robert. B. Baker; Ololade Olakanmi; Todd L. Savitt; Elizabeth A. Jacobs; Eddie Hoover; and Matthew K. Wynia, "Segregation, Civil Rights, and Health Disparities: The Legacy of African American Physicians and Organized Medicine, 1910-1968," \textit{Journal of the National Medical Association} 101, no. 6 (June 2009): 513-527. \\
\textsuperscript{417} "OPMS Meeting minutes," June 8, 1965, OPMS Collection, LRCTU.
reluctance to enforce the provision, writing in his letter that he was "only passing on federal government's interpretation of the Civil Rights Act." Both the OPMS and state medical society opposed the requirement. In anticipation of the requirement, in August 1965 the newly integrated OPMS passed a resolution—over the objection of the new Black members—to not "violate the freedom of physicians" by requiring them to sign the non-discrimination form. The state medical society also voted to advise physicians to refuse to sign non-discrimination documents. State president Dr. Charles Odom argued that opposition was not based on racism or in opposition to the Civil Rights Act of 1964, but instead about principles of freedom: "any demand that a physician sign a written agreement that he will abide by a law is contrary to our American way of life." Bodin and Odom went to Washington to meet with HEW, and got the department to drop the signing. Instead, bills for payment to the physicians from the federal government for services rendered through the vendor program included a non-discrimination statement as a reminder. After they secured this change, the Louisiana State Medical Society issued a statement supporting the right of white physicians to not treat Black patients: "All persons concerned agreed that the patient has free choice of physicians and the physician has a right to accept or not accept any individual as a patient."

Integration at Charity

Despite this initial resistance, many African Americans remained hopeful in the second half of the 1960s that the lawsuits, Civil Rights Act of 1964, and Medicare and Medicaid would lead to the end of the segregated health care in New Orleans. The most

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419 "OPMS Meeting minutes," Aug. 26, 1965, OPMS Collection, LRCTU.
significant integration occurred at Charity Hospital, which witnessed an immediate
increase in the number of Black patients from under 50% prior to the integration orders,
to 77% of Charity's patients in July 1965, three months after the directors announced the
end of segregated wards, and nearly a year after the Civil Rights Act of 1964 forbade the
practice. However, official integration did not lead to the end of discrimination. Many at
the hospital defied the court and federally mandate to end discrimination, leading to years
of confrontation between African American patients and the white employees and
administrators of Charity. In the face of this continued discrimination, Black patients
pushed for better treatment. In 1966, African American residents formed a "Committee
for Better Health Services." In April, they sent a letter to the administrators of Charity
Hospital asking to speak with them. When they received no reply, they created a petition,
and sent it, along with documented complaints of poor treatment and racial
discrimination to the hospital compiled in 1965 and 1966 by the NAACP. They also
asked the Office of Economic Opportunity to help them distribute the petition citywide,
and *The Times Picayune* printed it in June 1966. The petition read as follows:

  Whereas, we the poor are unemployed, and underemployed, forced into Slum
  Housing, having no money, are subjected daily to conditions which contribute to
disease, poor health, chronic illnesses, high infant deaths and many other
unhealthy atrocities. Having already requested an audience with the heads of
Charity Hospital by our committee, and having not yet heard from Charity, and
being concerned with poor communications between Charity Hospital and the
consumers of medical services, who are for the most part, "poor people," and,
having documented statements from citizens at Charity Hospital. We the
undersigned request an open hearing to air documented complaints against you;
and, to work to eliminate the cause of the many problems that affect the health of
the poor.

  The most documented complaint was delay in treatment, with white patients given
higher priority over Black patients in the waiting room. Lois Jones detailed how she had
waited in the intake office for seven hours with a rheumatic fever of 104 degrees, before her husband drove her to a friend of her father's home; he made a call to a contact who worked at the hospital and finally got her admitted. Others without these types of connections were not as fortunate. The NAACP conducted interviews with workers at Charity, and found that administrators regularly required African American patients to undergo lengthy eligibility checks. Patients had to provide proof of residency in Louisiana for at least six months and steady employment. Charity set an income limit of $225 dollars monthly for an individual person, with an additional $25 dollars allowed monthly per child. Patients who met the requirements received an eligibility card for Charity Hospital's services. However, many individuals seeking treatment in Charity's emergency room did not have eligibility cards, or bring with them the necessary proof to obtain one. In the emergency room, administrators often required Black patients to first prove they were eligible before they offered treatment, while white patients received care before their status was determined. As detailed by Myrtle Perron: "They don't care if you're dying or what; you have to wait until they find out if you are eligible." Hubert Alvin described how after he was attacked and severely wounded by a gang, and the caseworkers refused to treat him, even though he was a full-time student at Southern University of New Orleans and thus was automatically eligible for care. Alvin presented his student identification card, but the caseworker demanded he present documents detailing his financial situation. While Alvin used the bathroom, a white supervisor, seeing that Alvin had previously served in the military, called the military police to have

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him arrested, even though he had been honorably discharged. Elsie Bazile-Brown, a Black worker at Charity, reported to the NAACP in January 1966 that she witnessed an African American woman come in with severe burns on her hands and arms. The white supervisor insisted that the Black caseworker take her out in the hallway and determine her eligibility before they treated her burns. Mystis Keelen described her problems getting an eligibility card from the hospital. Keelen, a mother of six, earned $24 a week, far below the eligibility threshold, but the hospital refused to give her the card accusing her of being dishonest: "They said I was lying because nobody could get along on $24 dollars a week with six children." When they rejected her, the caseworker told her to instead "find the father of my children and make him support them." Brenda Soublet told the NAACP in March 1966 that her son Louis was attacked and beaten unconscious. She brought him to the hospital, but before he could be treated, a white supervisor administered ammonia to wake him and question him about his eligibility. 

The process of proving eligibility, reserved primarily for Black patients prior to treatment, often proved arduous and humiliating. In 1969, the Human Relations Council—an interracial group of civic leaders with membership determined by citywide elections—detailed the complex task of trying to receive care at Charity. In two articles written by physicians, "Are You Strong Enough to Be Sick?" by Dr. Jeff Gordon and "Poor People's Panacea" by Dr. Dan Bloomenthal, the two doctors detailed the problems at the hospital and called for needed improvements. Bloomenthal described the process of using Charity as such: "For the person who cannot afford a personal physician and entry into the regular medical care system, adequate health care may be an impossibility; 

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421 "Report of the Committee for Better Health Services," April 1966, NAACP Collection, UNO.
degradation and dehumanization are certainties.” Patients first had to prove their financial eligibility for Charity's services, as detailed above. Individuals could have the income requirement waived by physicians working for LSU or Tulane (all white until the late 1960s). Additionally, many whites wrote to the mayor, asking him to help get the income requirement waived, a task Mayor Schiro repeatedly did in the 1960s. Schiro wrote over one hundred such letters in 1963 alone for white constituents. With no representation at the hospital, among the physicians at LSU or Tulane, or in the City Council and mayoral administration, African Americans who exceeded the income requirement, but still lived in poverty and thus could not afford a private hospital, had no means to seek treatment at Charity could receive not hospital care.

For those who qualified, Charity recommended patients bring with them to the hospital—even when seeking emergency treatment—contact information for their employer and a letter from their employer or other proof of employment like a paycheck. Patients were expected to provide a copy of their 1040 tax return, their welfare card, hospital insurance policies, proof of residency like bills sent to their address, and copies of previous hospital bills and time payment plans. Granting of eligibility to use the hospital for non-acute cases usually took weeks or months. If a patient needed medicine that they could not afford, they had to go through a separate process. First, they had to visit the Social Services Department. From there, they would then have to visit the State Welfare Department. Then, they were directed to Charity to have a physician fill out a form saying they needed the medicine. If they completed these steps, they would be

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423 "1963," Charity Hospital Folder, Mayor Victor Schiro Collection, CANOPL.
granted a card that entitled them to a prescription, but not refills; to obtain a refill, they had to go through an additional process. If a patient wanted immunization shots, they had to visit a neighborhood center, as they could not obtain the shot directly at Charity. For birth control, they had to go to a family planning center. For other medicine, they had to go to City Hall. Patients receiving medical treatment rarely saw the same physician at Charity twice, even if they were undergoing long-term treatment. Patients primarily received treatment in open wards with no privacy—as opposed to individual rooms available at private hospitals. There was virtually no follow-up done by the hospital and no real options for preventive measures. Overall, Bloomenthal found the system to be confusing, degrading, and extremely difficult to navigate, perhaps purposely so to discourage use and to punish the poor. He reflected, "One finds that he has been fed into a huge depersonalizing machine that strips him completely of human dignity."424

Beyond this byzantine process, Black patients continued to face other indignities at Charity. In their 1966 petition, the "Committee for Better Health Services" noted that the hospital continued to require Black patients to sit on a separate side of the emergency waiting room from whites, a practice forbidden under the Civil Rights Act.425 This was not the only documented cases of segregation at Charity in the late 1960s. The NAACP reported that the hospital continued an unofficial policy of separate water fountains, benches in waiting rooms, and even telephones for white and Black patients and

424 "Human Relations Council, July 1969 Report," NAACP Collection, ARC.
425 "Petition of A Group for Better Health Services," NAACP Collection, UNO
workers. The hospital's school for children of patients segregated the children by race for lessons, and the hospital refused to admit Black babies to the nursery.

Black patients also suffered from physical and sexual assaults by white doctors at Charity. Victoria Jones reported one such incident in October 1966. A caseworker gave Jones a referral slip to see a physician at Charity's clinic for her hemorrhoids. When she visited the clinic, she gave the slip to the nurse, who attached the paper to the doctor's clipboard, which also contained her chart and a description of her ailment. However, when she saw the doctor, he claimed not to have her slip nor to know what was wrong with her. She tried to explain her problem, but the doctor interrupted her and told her "I'm not interested in that," and refused to treat her. She tried again to explain her ailment, but the doctor again cut her off and began cursing her, telling her "you don't have as much brains as a jackass or a monkey." She finally got the doctor to examine her, but as he did so, he punched her in the back and told the woman to "get your bitch self out of my room." Upon leaving, Jones reported the incident to another doctor and to the hospital's chief administrator, Dr. Charles Mary. Jones informed Mary that this was the second time a white physician from Tulane University working at Charity had physically assaulted her. She also reported the incident to the NAACP, who in turn pressed Mary to investigate. Mary promised to do so, but promptly dropped the matter, and neither Jones nor the NAACP heard back from Mary about the matter.

Charity continued to play a controversial role with its decades old relationship to the police and the Orleans Parish jail. Officers would take African Americans they

427 "Report," May 25, 1966, NAACP Collection, UNO.
428 "Complaint of Victoria Jones," Oct. 11, 1966, NAACP Collection, UNO.
assaulted to Charity for quick treatment before bringing them to the jail. In her complaint filed with the NAACP in September 1968, Eliza Reynolds detailed how police falsely arrested her 25 year old son Joseph Lee and accused him of burglary. The police came to her home, dragged Joseph Lee off the swing he was sitting on, and severely beat him. They took him to Charity Hospital where a doctor hurriedly treated him for six broken ribs and an eye out of the socket, then immediately brought him to jail, where they beat him again.  

Workers also made complaints to the NAACP over racial discrimination in hiring, promotion, and treatment by white supervisors. The NAACP sent these complaints to Charity, but again received no response. They launched their own investigation and determined in March 1966 that white supervisors continued to deny Black workers promotions, good assignments, and leaves of absence. The organization also documented that Charity had no Black supervisors in central services, receptionists, elevator operators, plumbers, electricians, guards, telephone operators, plasterers, or ambulance drivers. The hospital placed no Black nurses or physicians in the nursery, and grouped all Black nurses, aides, and maids on the 12th floor. When the NAACP conducted their investigation, they reported that white supervisors placed "much pressure" on Black workers to not cooperate with the NAACP, and threatened to fire anyone who did. In his report filed with the NAACP in June 1968, James Sanders, an orderly at Charity, detailed how his supervisor called the police and had him arrested that April. On his break, Sanders went to speak with a receptionist, who then left to talk with a patient.

429 "Complaint of Eliza Reynolds," Sept. 29, 1968, NAACP Collection, UNO. For more on the history of police brutality in New Orleans, see Moore, Black Rage in New Orleans.

430 "Report," May 25, 1966, NAACP Collection, UNO.
Sanders sat at her desk while he awaited her return. Two guards came and told him he could not be there. The guards then called his supervisor and accused Sanders of cursing at them. The supervisor had him arrested. When the head nurse asked the supervisor if an apology would suffice rather than Sanders being taken to jail, the supervisor, a Mr. Davis, replied: "I've got to show these people something." When another nurse approached and asked if she could help, Mr. Davis told her to "shut up" or he'd have her arrested too. Sanders noted in his statement to the NAACP that it was a "definite racial incident because of the timing of when it happened"—the day after the assassination of Martin Luther King, Jr. Sanders was one of many who filed reports with the NAACP for wrongful termination of employment at Charity Hospital, or for being unjustly kicked out of the hospital's nursing program, which continually dismissed Black students with no cause.431

**Private Hospitals Defy Integration**

While African Americans continued to face discrimination and a dehumanizing system at Charity, few ended up at the formerly all-white private hospitals in the city, many of which even more overtly defied integration. Despite issuances of assurances of non-discrimination by all hospitals in New Orleans, segregation of medical institutions continued. For example, at the Home for the Incurables, a convalescent facility for those suffering from long-term or terminal health problems, the hospital's board passed a resolution to integrate in June 1965 in accordance with the Civil Rights Act of 1964. For decades, they had provided care for Black patients at one building, and whites in another. Although they pledged to desegregate in 1965, the hospital continued to house Black and

431 "Complaint of James Sanders," April 30, 1968, NAACP Collection, UNO.
white patients in separate buildings until 1970. The Home for Incurables was hardly the only health care facility to violate the Civil Rights Act. Many hospitals refused to hire African American doctors, nurses, and other workers. Those that found employment in health care, faced harassment and threats from white co-workers and supervisors. In April 1966, Ellis Hull Jr. sent a letter to the Department of Justice documenting his experience of racial discrimination. In the late 1950s and early 1960s, Hull worked as a porter at Charity Hospital for six years, before leaving to work in another field. Hull returned to the hospital in early 1966 at the same position, but they fired him after three months with no cause. He then got a job at Touro Infirmary. Although the hospital hired him as a porter, they proceeded to use him as a janitor. At first, Hull did not complain, as he needed the work. However, his supervisors made his work exceptionally difficult, assigning him to changing shifts, constantly giving him new tasks, and issuing contradictory orders. For several weeks, one white supervisor literally stood behind Hull and followed him around, watching him do his work. Hull noted in his letter to the Department of Justice that he believed this harassment stemmed from white opposition to integration. Hull wrote: "I think these people just wanted to see me as a CORE or NAACP worker, rather than a citizen looking for a job." For these white workers, Hull represented the civil rights groups that required desegregation and the hiring of African Americans, and they trained their animosity on him.

Others experienced similar treatment. The only five Black nurses employed at the Ear, Eye, Nose, and Throat Hospital filed a complaint with the NAACP in April 1968.

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432 "Home for Incurables reports," New Orleans Social Council Collection, LRCTU.
that the hospital remained segregated in nearly every way: a separate ward for Black adult patients; Black babies were not placed in the nursery ward but rather in the Black adult ward; every African American nurse, except for a very light-skinned woman, worked in the Black ward; doctors and administrators addressed white nurses with their title in front of their name, but only addressed Black nurses by their first name; the hospital paid Black workers less; Black nurses had to congregate and punch their time cards in the basement, unlike white nurses who did so on the first floor; and the hospital even used separate thermometers for Black and white patients.\textsuperscript{434} Black nurses at the Veterans Administration Hospital filed a list of grievances with the institution in June 1968, documenting "bias throughout the hospital." The women described "constant harassing treatment" and "mental cruelties" intended to "force nurses to quit an already understaffed Nursing Service." Their list of grievances listed the following specific complaints: inequities in promotion to administrative positions; failure to consider seniority in promotions to administrative and/or preferred positions; unfair requirements for promotion to administrative positions, including mandating degrees for Black but not white nurses; filling of positions in secrecy rather than on a competitive basis, to prevent African Americans from applying for them; and the dismissal of Black nurses for unfavorable criticism by white supervisors.\textsuperscript{435}

Although the New Orleans branch of the NAACP brought these health care discrimination complaints to the Department of Health, Education, and Welfare, the federal agency took little action in the late 1960s. In March 1967, the regional program

\textsuperscript{434} "Report," April 10, 1968, NAACP Collection, UNO.
\textsuperscript{435} "Concerned Negro Nurses at VA Hospital," June 1, 1968, NAACP Collection, UNO.
director of HEW's Office of Equal Health Opportunity wrote to the administrators at the formerly all-white private hospitals in the city asking them for data on admissions by race to determine their compliance with the Civil Rights Act of 1964. The hospitals—some of which still identified patient's blood to segregate by race and carried out other practices of discrimination based upon the patient's race, identified on the admission form—refused the federal's government's request to count patients by race, arguing doing so would violate freedom of the hospitals and patient confidentiality. In April 1967, the OPMS voted to endorse this decision. HEW ultimately refused to press the matter, and thus had no data to show hospital violations.436

**White Flight Hospitals**

In addition to the federal government's failure to enforce compliance in the city's private hospitals, the federal government played another role in the perpetuation of apartheid health care: providing funding through the Hill-Burton Act for "white flight" hospitals. Like other Southern cities, white migration to New Orleans's suburbs began in the immediate post-war period. Metairie, for example, developed in the 1940s when the innovation of the wood screw pump allowed the draining of former swampland. White New Orleans began moving to Metairie and other suburbs, lured by cheaper housing costs, lower taxes, and larger lots. Government policies aided the suburban growth, with highway expansion projects, subsidies for oil that kept gas prices low, and federally backed mortgages. In the New Orleans area, as in many metropolitan regions, whites benefitted the most and made up the majority of the movers to the suburbs. White New Orleans had higher incomes that allowed them to purchase homes and afford mortgages

436 "OPMS Meeting minutes," April 11, 1967, OPMS Collection, LRCTU.
from banks or programs like the G.I. Bill, which were often denied to African Americans. As in the city, real estate agents played an active role in the creation of white suburbs by refusing to show or sell African Americans homes.437

Government funds also aided the construction of hospitals, another driving factor in suburban growth. Federal Hill-Burton money and municipal bonds funded the construction of hospitals, with nearly all private hospitals built prior to 1964 refusing to admit Black patients and public hospitals only treating them in segregated wards. Municipal bonds and Hill-Burton aid helped fund the building of Metairie Hospital, which opened in 1947; St. Tammany Parish Hospital (1954); Chalmette General Hospital (1954); St. Bernard General Hospital (1959); Slidell Memorial Hospital (1959); West Jefferson General Hospital (1960); Methodist Hospital (1963); Lakeside Hospital for Women (1964); East Jefferson General Hospital (1971); and Lakeview Regional Medical Center (1977), all constructed in the suburbs of New Orleans. The extension of federal highways and gas subsidies also helped bring in patients, and it expanded municipal services that provided them needed gas, water, and electricity. Clinics and private practices followed these hospitals to suburbs as well.

Health care institutions did not just benefit from "white flight" policies; they too served as pull factors by attracting white residents to the suburbs. In St. Tammany Parish, located across Lake Pontchartrain from New Orleans, health care facilities became a key driver of development of the sparsely populated area, building on a history of apartheid

health care. Starting in 1878, St. Tammany proprietors promoted the rural area as a health mecca, particularly during the yellow fever outbreaks that afflicted the city until 1905. Thousands fled New Orleans during these epidemics, staying in St. Tammany hotels. Sanitariums began popping up in the late nineteenth and early twentieth century, especially in the 1910s as treatment facilities for tuberculosis patients. Promoters heralded the parish as the "Healthiest Place on Earth," claiming unique health benefits from the lake, the mild climate, pine trees, and local milk. The National Anti-Tuberculosis League established a sanitarium in St. Tammany in 1907. The facilities, however, only provided treatment for white patients, a reflection of the racial attitudes of the parish's white residents. In 1894, residents protested the proposed placement of a hospital for sufferers of Hansen's Disease, also known as leprosy, in St. Tammany. Speaking on behalf of other residents, a Colonel Richardson voiced his opposition in the local newspaper, The St. Tammany Farmer, arguing that "many of the lepers here, I judge, are negroes," who would "escape if there is any chance to do so. We all know how negroes are." When the Louisiana Tuberculosis Association attempted in 1918 to locate a tuberculosis camp for Black patients in the area, residents fiercely protested. The Farmer stated that while residents welcomed white sufferers, they "draw the line at being made the dumping ground for negroes." In April, the Covington and Mandeville town councils voted to refuse permission for the camp. In 1942, residents again protested, this

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438 St. Tammany Farmer, May 26, 1894, 182.
439 St. Tammany Farmer, March 1, 1918, 184
time over the placement of a facility for treating women with syphilis, funded by the state and federal governments, as African Americans had higher rates of the infection.440

Despite its health industry, St. Tammany Parish remained relatively small through the 1940s, with only 23,619 residents (69% white and 31% Black) in the 1940 census. However, during the 1950s the population began growing rapidly, pushed by school integration, and pulled by the opening of the Lake Pontchartrain Causeway in 1956. The relocation of an aluminum factory, sugar refinery, and oil refinery from New Orleans to St. Tammany and the opening of a new general hospital also created population growth. Residents, primarily the Women's Progressive Union of Covington, began a campaign to create St. Tammany Parish Hospital in 1946, securing $240,000 from Hill-Burton funding and $175,000 through a bond issue voted on by the St. Tammany Parish Police Jury. Opened in 1954, the hospital added a second wing in 1958, an addition in 1961, and another wing in 1974. Reflecting the past history of discrimination, the hospital was segregated, offering three rooms—out of thirty—for Blacks, a ratio of 10-1 rooms for whites versus Blacks, despite the latter making up 27% of the population at the hospital's opening.441 The addition of St. Tammany Parish Hospital in Covington and Slidell Memorial in 1959 helped the population swell from to 38,583 in 1960 and become even more white (73% white, 27% Black). During the 1960s, the peak period of white flight from New Orleans, the population of St. Tammany witnessed its largest period of growth.

ever, expanding to 68,585 residents by 1970. Almost all the influx to St. Tammany was by whites, with the parish population becoming 87% white and only 10% Black.442

This phenomenon occurred in other suburbs. In Jefferson Parish, east adjacent to New Orleans, the expansion of Ochsner Foundation Hospital served as one of the largest pull factors. The hospital became the leading employer, not just in the parish, but in the entire state. However, the hospital started as a whites-only institution, and fiercely resisted integration. Alton Ochsner, founded the hospital and guided much of the hospital's growth. In the 1920s, Ochsner served as the chief of surgery at Charity, and gained national renown as the first physician to link smoking to lung cancer. While a professor at Tulane, Ochsner pushed the school to break their ties with Charity Hospital and instead create their own private hospital, as well as a clinic which Ochsner would head. When the school demurred, Ochsner and four other physicians established the Ochsner clinic, the first group medical practice in the Deep South, in 1942 in uptown New Orleans. In 1944, the group created the Ochsner Medical Foundation, which focused on research and graduate training of physicians and surgeons, and then sought support to create their own hospital. In 1946, the Foundation purchased Camp Plauche in Jefferson Parish from the federal War Assets Administration, and converted it to a whites-only, 200-bed hospital. The former army site contained 53 wooden-frame buildings, though, and the foundation looked for a more modern structure. In 1952, with money from a successful fundraising campaign and Hill-Burton funding secured from the state, they started construction of a new, five story, whites-only, 250-bed building on 22 acres in Jefferson, just outside of New Orleans boundaries. The hospital campus included the

Brent House Hotel, used for long-term patients and physicians’ offices and the Libby Dufour residence, a building for nurses and physicians, which was opened in 1954. They added a helicopter landing pad in 1955, a research building in 1959, and the relocated Ochsner Clinic in 1963. In the 1960s, the hospital became a leading center for research, particularly on cardiovascular disease, and served as a cutting-edge site for medical procedures, including the Gulf South's first kidney transplantation. Over the next half century, Ochsner would acquire other hospitals and become both the largest employer in the state and the largest private health care system in the region.443

The all-white institution was aided by several factors unavailable to Flint Goodridge Hospital. The founding partners of the clinic were all professors at the segregated Tulane University and doctors at the segregated Charity Hospital. Through the wealth acquired in working in the apartheid health care system, the founding partners gained the capital necessary to start their own practice. The partners also solicited patients from their work at Charity and Tulane to create a financially secure, white clientele. The partners also used their connections to secure the hospital's first location, purchased from the military; to solicit money during their fundraising campaign in the early 1950s; and to gain Hill-Burton funding the same period the state repeatedly rejected Flint Goodridge's requests for expansion, even though the number of white beds already far outnumbered beds for Black patients, a violation of the legislation.

The role of hospitals in facilitating white flight can most explicitly be seen in the creation of the Methodist Hospital in New Orleans East. New Orleans East first developed as a neighborhood of the city in the early twentieth century, as the Gentilly

443 Lincoln, "Tulane University School of Medicine and Charity Hospital."
neighborhood expanded. In 1923, the Industrial Canal opened, followed by the Intercoastal Waterway in 1944, which physically separated the East from the rest of the city, and effectively slowed growth of the East. Development picked up again in the late 1950s through the 1970s with white flight to new suburban subdivisions. Mayor Schiro personally championed the growth of New Orleans East, as he hoped to encourage movement to the area, within official city bounds, in lieu of migration to suburbs in other parishes. Industry—primarily shipping, warehouses, and manufacturing—helped pull development, with the Intercoastal Mississippi River-Gulf Outlet Canal, completed in 1965, aiding the placement of inner harbor wharves along the Industrial Canal. NASA also took over the Michoud Assembly Facility, constructed during World War II as part of the Higgins Industry's war production efforts, in 1961. The area also benefitted from a strengthened levee system after severe flooding during Hurricane Betsy and the building of Interstate-10, started in 1957.444

The construction of Methodist Hospital, opened in 1968, also helped the growth of New Orleans East. The idea for the hospital originated from members of the Gentilly Methodist Church in 1959, who were concerned about the lack of medical care available to the residents of the area. In 1961, the Gentilly Hospital Association incorporated and later became the Methodist Hospital Association. Church member Kenneth Schor, who first suggested the hospital, and Reverend John Koelemay led the $3.5 million dollars fundraising campaign, first by soliciting support from every Methodist minister in the state; business and civic leaders; and government funding. Serving as President of the Methodist Hospital Association, Schor solicited the support of Mayor Schiro and the

444 Campanalla, Citiscapes, 274.
OPMS, the latter primarily for their application for Hill-Burton funding. The hospital association sent both the OPMS and the mayor a document entitled "Memorandum Supporting Methodist Hospital" with several arguments in favor of the hospital.

First, the association noted a noted significant drop in the patient base for existing hospitals in Orleans Parish with a 9.9% decline in population from 1950-1959 due to white flight to the suburbs. Those fleeing included physicians, many of whom had moved their offices to the area around the lake. In contrast, they highlighted the "exploding population" in the area of the proposed hospital, one of the white flight destinations, which witnessed a 67% increase in population in the same time period. Methodist Hospital would meet the medical needs of the growing population of New Orleans East. In addition to providing treatment for the acutely ill, the hospital planned to offer long-term care, psychiatric care, and services for the elderly, a growing population in New Orleans and throughout the country.

Second, the hospital boosters pushed for the hospital as "essential in attracting new industry to any community." Schor argued that a modern medical center would help lure commercial and industrial businesses to locate in New Orleans East as the hospital would service their employees. Mayor Schiro, who became a vocal advocate for the hospital, fully embraced the hospital board's vision, personally sending out letters and to business and civic leaders asking for donations. Speaking at an event marking the anniversary of the opening of the hospital in 1969, Schiro stressed the role of the hospital in helping the East develop, which he argued was of vital importance to the city's overall success. The East, Schiro stated, possessed the largest land area for growth. Without this space, he warned, the city "would soon be strangled with a glut of population and
buildings, unable to reach the destiny predicted for us." The destiny he spoke of was for the city to become a "manufacturing center" based primarily out of the East. Schiro predicted that half a million people would end up in New Orleans (nearly the city's entire population at the time). "With this anticipated growth staring us in the face," he told the crowd, "we cannot afford to think of less than realizing the full goal" of an additional $500,000 for hospital expansion. Thus, in Schiro's proffered vision, Methodist Hospital was linked to the city's future. The hospital, he stated, "fills a need felt by every person living and working in this part of our city, both present and future." 445

Third, beyond attracting industry, both the hospital leaders and the mayor celebrated the hospital itself as a significant employer. In his fundraising letter, Schiro called the hospital "a new industry"; similarly, Reverend Koelemay, who served as the hospital's promotional director, spoke of "what the hospital means to the community as an industry." 446 Schiro and Koelemay were hardly alone in their assessment of the hospital as an industry. By the late 1960s, medical costs nationwide had soared buoyed by health insurance and growing average incomes, and hospitals had become profitable, with companies and entrepreneurs increasingly interested as investment opportunities. 447 The Methodist Hospital planned to operate as an independent hospital, with no backing from a hospital corporation. However, the hospital benefitted from support from powerful companies. Members of the hospital's building fund advisory board included executives from Merrill Lynch, Hibernia National Bank, the National Bank of Commerce, Southern

445 "Speech Anniversary of the Opening of Methodist Hospital," Sept. 25, 1969, Mayor Victor Hugo Schiro Collection, CANOPL.
447 Starr, The Social Transformation of American Medicine, 290.
Bell Telephone, and the Coca Cola Bottling Company. The hospital's leaders projected their annual income to continually increase—nationwide, income at private hospitals nearly doubled in the second half of the 1960s—as New Orleans East's population grew to the projected 500,000 residents.\textsuperscript{448} The increasing population would fuel the hospital's growth of services, and they projected to be one of the two largest employers, along with the Michoud plant, and employ hundreds of New Orleanians.\textsuperscript{449}

Fourth, the hospital's founders and promoters appealed directly to issues of racism. In their "Memorandum," the hospital association stated they decided to locate the institution in its proposed site so that it would serve a majority white population. The African American population, which they noted was concentrated in the southern section of the ninth ward, would be "outside of the expected service area," Black residents primarily used St. Bernard General Hospital (opened in 1959), whose service area covered the southern section. The proposed Methodist Hospital site would service the northern section, an area that was nearly exclusively white. The memorandum highlighted the recent increase in the Black population in the southern section, and argued that the hospital could help counter this by facilitating the growth of the northern part which would see an "accelerated increase in the white residents." The hospital association made their desire to serve white patients and help the white population grow explicit, and used it as a main selling point of the hospital to the mayor, the OPMS, and other supporters.

\textsuperscript{448} Starr, \textit{The Social Transformation of American Medicine}, 291. \\

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The fundraising campaign proved successful, bringing in $1.9 million from the community, in addition to the $2.6 million from Hill-Burton aid, and a $3 million mortgage loan. Construction started in 1967, and the hospital opened in 1968. With an additional expansion started the following year, the hospital contained 181 beds by 1971. New Orleans East saw steady growth in population in the 1960s and 70s as the hospital expanded, although never reaching Mayor Schiro's vision of half a million people. Up until the 1980s, the vast majority of residents were white, proving the hospital association's predictions correct. The hospital, the Michoud plant, and the city's improvement efforts turned New Orleans East into a white suburb within city bounds. Despite opening after the passage of the Civil Rights Act of 1964, the hospital, by design of its location and purpose, served a mostly white patient base and hired mostly white workers. So much so, that Methodist Hospital (later renamed Pendleton Methodist Hospital) was one of the city's hospitals sued by Black residents and charged with racial discrimination by the Department of Health, Education, and Welfare in the 1970s, which will be addressed in chapter seven.
CHAPTER 7: TWO-TIERED HEALTH CARE, 1965-1974

Introduction

Attorney John Dowling was adamant that the residents of the Tulane Gravier neighborhood opposed the proposed expansion of the medical district being debated at a December 1970 meeting of the New Orleans City Council. Dowling argued the plan would mean forced relocation for hundreds of mostly Black residents and homeowners. "There is no doubt in my mind that the majority of the people in this area don't want their homes taken away from them by a blue-ribbon board or some unthinking politician," Dowling told the council. Created in 1968, the new state agency the Health Education Authority of Louisiana (H.E.A.L.) planned to expand Charity Hospital, LSU Medical School, and Tulane University Medical School, as well as build a new hospital for Tulane, parking garage, medical offices, and housing for thousands of employees of the medical complex and medical school students. H.E.A.L. hoped to secure funding from H.U.D. to pay two-thirds of the $30 million dollars' project. The money would also help fund urban renewal of the surrounding area, replacing over 800 residences and businesses deemed "substandard," "deficient," or "blighted." Hundreds of mostly Black residents and business owners would potentially be displaced over their refusals to move, as the state granted H.E.A.L. the power of eminent domain. Speaking to the city council on behalf of the Owners and Tenants Association of Greater New Orleans (OTAGNO), Dowling was blunt: "When they confiscate our property, they will relocate us. I haven't heard this term (relocation) since the days of Hitler." 450

This chapter explores the post-Civil Rights period when the promise of an integrated health care system evaporated and the apartheid health care system became reentrenched, similar to what occurred in New Orleans a century earlier. This chapter starts with juxtaposed stories: the simultaneous attempts to expand the white Medical District, including the successful creation of Tulane University's new hospital, and the stymied work to expand Flint Goodridge Hospital, which entered into decline. It explores the creation of the state agency Health Education Authority of Louisiana and its urban renewal efforts to displace Black residents and businesses. This chapter also explores continued Black health activism, which took several forms. First, Black residents of Tulane Gravier organized against the expansion of the Medical District and displacement. Second, Black residents and the NAACP initiated litigation against the formerly all-white hospitals that continued to discriminate, leading to investigations by the federal government, and underminded by the failure of the federal government to enforce integration. Third, Black residents pushed for Health Department and federally-funded Model Cities health clinics in the public housing units and Black neighborhoods, and the Black Panther Party created their own People's Clinic in the Desire neighborhood; all the clinics proved short-lived. Finally, the chapter examines the transition of Charity Hospital to a "de facto" Black hospital, and the accompanying decrease in state funding and quality of care.

A Modern Medical Center

While these white flight hospitals grew, the two hospitals that served the majority of the city's Black residents, Flint Goodridge and Charity Hospital, entered into a steady phase of financial decline. Initially, the leaders of Flint Goodridge expected the
desegregation of health care to aid the hospital and result in it being a leading part of the growing health care sector in New Orleans. The Board of Management of Flint Goodridge looked upon the passage of Medicare and Medicare as a potential boon. While patient numbers had increased through the early 1960s, the hospital still faced concerns that made the projected steady stream of Medicaid and Medicare patients—and more importantly, government compensation—attractive. The hospital lacked a steady funding base beyond Dillard University. The hospital's average length of stay for adults of 9 days significantly exceeded the national average of 7 days, due primarily to their reliance on visiting physicians who earned income based on patient length of stay not on a set salary. This induced physicians to admit patients in the hospital for longer than necessary, financially benefitting the physician, but hurting the hospital. Because the hospital's patient base was primarily low-income and many lacked health insurance, the hospital continually struggled to collect unpaid bills. Finally, the hospital's expansion in the 1950s and increased services led to higher salary and operating costs.451

Almost immediately into the hospital desegregation period, Flint Goodridge experienced some negative effects. Although many formerly all-white hospitals continued to discriminate against Black health care workers, Flint's administrators noted in 1965 a "high turnover rate" as some nurses left for better salaries at other hospitals or with the federal government. This loss of workers forced the hospital to raise their nursing salaries to retain their employees, which cut into revenue. Hurricane Betsy compounded this financial hit by causing wind damage to the hospital. In response, the hospital temporarily closed several areas for years, which resulted in the hospital's first

reported decline in patients in over 15 years, and a drop in much needed patient payments. Even worse, administrators discovered their policy did not cover wind damage, so the hospital had to pay for the repairs out of their revenue.\textsuperscript{452} That November, the hospital raised rates to make up for losses.\textsuperscript{453} However, administrators looked at the patient drop as an irregularity caused primarily by the storm, and continued to express optimism for the hospital's future. Hospital leaders believed patient numbers would increase again when Medicare and Medicaid went into effect on July 1, 1966. As such, the hospital attempted further expansion by offering to purchase public housing property from HANO in 1966. Writing on behalf of the Flint Board of Management in February 1966, Vice President Charles Kohlmeyer, Jr. noted the apprehension of board members over displacing HANO tenants on the property they hoped to buy, but stated that they believed "that the Community need for the expansion of the Hospital facilities outweighed the need for relatively few apartments which would be lost in the move."

HANO officials initially appeared willing to accept Flint Goodridge's offer of $370,000. However, HANO officials then reneged on the offer, and demanded more money, which led to negotiations that dragged on for several years. Kohlmeyer raised their offer to $425,000, but HANO replied that they would not sell for less than $525,000, and they would not turn over the property until all the tenants had relocated.\textsuperscript{454} With Flint Goodridge unable to raise that amount, HANO ended the negotiations and the deal fell through. Other local officials further curtailed the hospital's growth. In July 1964, the hospital applied to the City Property Office to close Toledano St. between Freret and

\textsuperscript{452} "Flint Goodridge Board of Management Minutes," Sept. 27, 1965, FGHCDU. \\
\textsuperscript{453} "Flint Goodridge Board of Management Minutes," Nov. 29, 1965, FGHCDU. \\
\textsuperscript{454} "Charles Kohlmeyer, Jr. to J. Hilbert Schieb," Feb. 2, 1966, FGHCDU.
LaSalle streets, fill in the street, and use it for a new building or parking lot. The department rejected the claim; after a series of appeals and hearings that lasted three years, the city again denied the move, ending the struggle in April 1967.455 While the city had pledged to end discrimination in health care, little seemed to have changed in the municipal government's attitudes towards the Black hospital.

Administrators still had hopes for expansion though, pinned primarily to the enactment of Medicare and Medicaid. Flint Goodridge's leaders strongly believed these two programs would increase Black usage of health services, and that Medicare and Medicaid would provide a stable source of income for the hospital. Unable to foresee the future problems of under-compensation from Medicare and Medicaid, the hospital again applied for Hill-Burton funding. In November 1965, the State Department of Hospitals announced the further availability of Hill-Burton funding for New Orleans's hospitals. The department anticipated that when Medicare when into effect in 1966, the resulting increase in patients in the New Orleans area would lead to a projected need of 295 more hospital beds. Flint Goodridge's administrators requested to add on to the hospital to create 100 of these beds. They noted that in a reversal of the slight decline the hospital experienced after Hurricane Betsy in late 1965, patient use had increased from early 1965 through early 1966, leading to a shortage of beds.456 Hospital representatives noted that Flint's occupancy rate of 103.5% compared to the city-wide average of 75.3% demonstrated the need for more beds for African American residents. With the over occupancy of the previous year in mind, they strongly urged the state to award Hill-Burton funding to allow the hospital to have a 260-bed capacity. Administrators

455 "Charles Kotemeyer to Al Fluery," April 19, 1967, FGHCDU.
456 "Flint Goodridge Board of Management Minutes," March 24, 1966, FGHCDU.
contacted Congressman Hale Boggs in hopes of his assistance in securing the Hill-Burton funding. Under the 40% compensation formula available at the time through Hill-Burton, the hospital anticipated federal funds to $1.192 million dollars of the $2.98 million dollars estimated cost, leaving the hospital to raise $1.788 million dollars through a new fundraising campaign.

Leaders envisioned hospital building space growing from 69,451 to 160,000 square feet, more than doubling in size. Even after this growth of size and beds, the administrators believed the hospital would operate at "near capacity" and be a "financially sounder operation." Additionally, the Board wanted to build a new 93-bed, five-story nursing home on adjoining property for $685,000 dollars, financed through Fair Housing Administration funding.

Flint Goodridge's vision for an expanded hospital in some ways rested on complex and perhaps even contradictory ideas. African American civic leaders fought hard for desegregation of the city's institutions. However, some worried about the fate of the city's Black institutions like Flint Goodridge. Would integration lead to a massive decline in Black usage of the hospital? Would whites enter as patients? The hospital's administrators certainly hoped white patients would come, and the hospital made a concerted effort to attract white clientele. Consultant Jesse Bankston told board members in February 1967 that the extent of integration "will determine the future success of this hospital." While other previously all-white hospitals resisted integration, Flint Goodridge

457 "Flint Goodridge Board of Management Minutes," Dec. 12, 1966, FGHCDU.
459 "Letter Jesse Bankston to C.C. Weil," March 1, 1967, FGHCDU. Starting in the 1950s, the Federal Housing Administration began offering federal-backed mortgages for housing for the elderly.
pushed for integration to survive, based on the belief they needed white patients and doctors to remain viable. Their vision proved prophetic, as a lack of white patients helped doom the institution in following years.\textsuperscript{460} At the same time, the hospital's board members emphasized to state and federal officials that the health care needs of African Americans would continue to be best filled at Flint. Administrators wrote of their expectation that "there will be a tendency for Negroes to indicate a preference for admission to Flint Goodridge."\textsuperscript{461} This expectation proved only partially correct, as many upper-income Black patients would leave the hospital in the following years, taking away needed patient fees.

Ironically, doctors affiliated with Flint greatly precipitated this exodus. Almost immediately after Medicare went into effect, nearly all the white affiliated doctors resigned, and they transferred their higher income patients to other hospitals. By May 1967, 236 of 350 total physicians dropped their affiliation with the hospital.\textsuperscript{462} Due to the exodus of Black physicians during the postwar period, the hospital had made the decision in the 1940s to revert back to the earlier model of relying on white doctors with Black patients having privileges at the only hospital that would take these patients. Now, with the end of Jim Crow, those same white doctors abandoned the hospital, leaving it in financial turmoil. The removal of their patients proved particularly devastating because they made up the majority of the paying patients. In the wake of this move, Flint Goodridge reverted to its Great Depression role as the Black version of Charity Hospital, with an even greater percentage of indigent patients than in the 1930s.

\textsuperscript{460} "Letter Jesse Bankston to C.C. Weil," Feb 2, 1967, FGHCDU.
\textsuperscript{461} "Letter Jesse Bankston to C.C. Weil," Feb 2, 1967, FGHCDU.
\textsuperscript{462} "Flint Goodridge Board of Management Minutes," May 18, 1967, FGHCDU.
Nineteen sixty-six would prove to be Flint's last year in the black. Even with the increased occupancy from 1965 and most of 1966, and with $17,000 contributed by the Women's Auxiliary for 1967 alone, the hospital only broke even, and patient numbers dropped again.\(^{463}\) Between 1965 and 1968, patient use dropped 36.2%; births dropped 47.5%; and clinic visits declined 56.2 percent. In 1967, Dillard University recommended formally cutting ties with Flint Goodridge as they considered the hospital to be a "liability" due to "financial difficulties."\(^{464}\) That year the hospital reported losses of $72,000.\(^{465}\) To counter, the board raised rates again in 1967 for the third straight year.\(^{466}\) Thus began a desperate gamble. By raising prices, administrators hoped to bring in additional revenue from the remaining patients. Yet, by doing so they also risked driving away those that could not afford the new rates or who felt that the service at the hospital did not justify the higher fees.

In late 1968, the hospital experienced another temporary increase in patients, which they hoped was the sign that their earlier idea of Flint taking on a large percentage of the new Medicare and Medicaid patients was happening. Optimistic about the future, that May the hospital released a new "expansion report." The bold plan, with calls for an additional 150 in-patient beds (for a total of 278); a health clinic; long term care facility; child care center; educational center; a 160-bed long-term care facility; and separate Desire Housing Project and Lower Ninth Clinic Ward clinics, would create a massive institution that would serve an estimated 70,000 patients a year. Ignoring the evidence to the contrary, administrators still expected most of the city's Black, and many white,

\(^{463}\) "Flint Goodridge Board of Management Minutes," Feb. 13, 1967, FGHCDU.
\(^{464}\) "Flint Goodridge Board of Management Minutes," March 14, 1967, FGHCDU.
\(^{465}\) "Flint Goodridge Board of Management Minutes," Jan. 29, 1968, FGHCDU.
\(^{466}\) "Flint Goodridge Board of Management Minutes," May 18, 1967, FGHCDU.
Medicare and Medicaid recipients to use Flint Goodridge, and not Charity Hospital, especially in light of poor treatment at the latter:

[T]he experience the poor, particularly the poor Blacks, have endured at Charity Hospital, have often been anything but pleasant. For these reasons, it can, I believe, be safely assumed that once the Medicare and Medicaid programs are fully enacted, that most, if not all of the indigents of our community, will look away from Charity Hospital for their health needs.

Administrators also believed that Flint could apply for funding through the federal Model Cities program. Started in 1966 as part of President Lyndon Johnson's War on Poverty, the program offered funding for anti-poverty programs, including health clinics and public health initiatives.

The hospital that they envisioned meant both a significant leap forward towards serving as a modern health center, and a return to the hospital's original mission of increasing access. They set a goal of serving 70,000 patients. They wanted to address public health issues. They committed to the training and employment of Black physicians. The report described the need for services in the Lower Ninth Ward, which had "practically non-existent" health services, and as a result, had a high infant mortality and tuberculosis rate. In many ways, the hospital's clinic there would tackle the same issues it focused on when the new building opened in 1932. The Lower Ninth clinic would also be "community controlled" through a partnership with residents, and offer vocational rehabilitation in addition to health services. The mental health facility would offer special programs for treatment of alcoholism and narcotics addiction. The education center would offer a three-year associates degree in conjunction with Dillard and other universities, with the second and third years working at the hospital, and with a noted outcome of "upward mobility" as the ultimate goal for the students; a two-year work
study program in physical therapy; a program in inhalation therapy; and training in radiology. Finally, the plan envisioned a strengthened connection with the community. The hospital, the report urged, should take a holistic approach and partner with community leaders to "involve itself in the full range of urban ills besetting our communities," which it identified as crime, education, urban development, zoning, housing, land use, and transportation.\textsuperscript{467}

The plan never materialized. The state refused to give further Hill-Burton funding, which financially doomed the expansion. Furthermore, the municipal government carried out more measures to halt the hospital's growth. Already hemmed in by HANO—which refused to sell more property—the hospital could only extend in two directions. However, despite the protestation of the hospital, the City Council passed a zoning ordinance re-designating areas near the hospital as commercial; the commercial zoning made the hospital ineligible to buy that property. The only major building they carried out was the building a new nurses residence on the HANO property they had negotiated over for several years, finally secured but primarily paid for through bank loans.\textsuperscript{468}

In their 1968 expansion report, hospital administrators urged a holistic approach to medicine and partnering with community leaders to "involve itself in the full range of urban ills besetting our communities." The report identified these problems as crime, education, urban development, zoning, housing, land use, and transportation.\textsuperscript{469} In the

\textsuperscript{467} Joseph W. Thomas, "Expansion Report Flint-Goodridge Hospital," May 12, 1969, FGCDU.
\textsuperscript{468} "Letter Charles Kohlemeyer, Jr. to Broadus Butler," Dec. 4, 1969, FGCDU.
\textsuperscript{469} Joseph W. Thomas, "Expansion Report Flint-Goodridge Hospital," May 12, 1969, FGCDU.
following two decades, Flint Goodridge Hospital and Black New Orleanians would confront these problems, as the racial health gap again widened, and the promise of the end of apartheid health care evaporated. By the late 1980s, Black New Orleanians once again had mortality rate double that of whites, and Flint Goodridge closed.

**Health Education Authority of Louisiana (H.E.A.L.)**

Introduced originally in 1968, H.E.A.L.'s proposal initiated what would become a 50-year effort to expand the existing white medical district starting in 1968. By the mid 1960s, both LSU and Tulane wanted modern university hospitals, with the former hoping to tear down and upgrade Charity Hospital or establish a partnership with another hospital, and the latter planning to create their own hospital. Tulane had been operating a clinic in the Hutchinson Building since the mid 1960s, with more than 66,000 patients annually and an annual budget of $12 million, with 2/3 of costs coming from federal funding. However, federal funding had decreased in recent years, and operating costs had increased, leading to a deficit. The university still had a large endowment—over $51 million dollars—but hoped to find a consistent revenue source.470

In a paper titled "The Future of Medicine in Society is Tulane's Future," Tulane Vice President John J. Walsh argued that "the feeling of the American people, whether we agree or disagree with it, is that they are entitled to quality health care." This supposed change in viewing health care, coupled with rising incomes and insurance resulted in more health care spending and use of hospitals. Walsh urged Tulane to build

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470 "Tulane Annual Report 1969-1970," Tulane University Hospital Collection, LRCTU.
its own hospital to benefit from these changes.\textsuperscript{471} Tulane's administrators believed that creating their own private hospital would generate significant revenue.

Tulane's push for a hospital received great aid from the formation of H.E.A.L., with the explicit mission to help Charity, LSU, and Tulane acquire more property in the medical district. Leaders of and lobbyists for LSU and Tulane worked for several years to introduce and win support for H.E.A.L. Proponents argued the medical district was "once renowned as a great concentration of medical education and care," but had now been surpassed by centers in other cities, including Houston and Birmingham. They noted concerns over patient loss, modernization, and changes with new policies like Medicare. They also warned if LSU and Tulane could not build new facilities—with government aid—they would "vacate" the medical district and "Charity's demise would only become a matter of time." "Downtown blight," they predicted, "would spread" as a result. In contrast, if the institutions expanded, "an area destined for decay would become one of the community's bright spots, a vibrant area producing opportunities and new wealth, as well as better health for the community, the state, and even the nation.\textsuperscript{472}

The 1968 H.E.A.L. legislation authorized the creation of a board of directors composed of business leaders, lawyers, heads of insurance companies, members of the Chamber of Commerce, and led by hospital management executive Jack Aron and Dr. J. Jefferson Bennett, who previously helped develop and direct the planning for the University of Alabama's Medical Center Complex, which took over sixteen blocks in downtown Birmingham. The legislation also created twelve representatives to the board:

\textsuperscript{471} "Tulane Annual Report 1969-1970," Tulane University Hospital Collection, LRCTU.
\textsuperscript{472} "H.E.A.L. Pamphlet," Charles Cassedy Bass Papers, LRC, Tulane.
two from Tulane, two from Charity, two from LSU, two from the executive board of the
Louisiana State Medical Society, one from the Louisiana Dental Association, one a free
appointment by the governor, the governor himself, and one selected by the mayor of
New Orleans. H.E.A.L. could initiate voter-approved bonds for the eligible institutions to
buy property and build new structures and parking lots, use eminent domain to acquire
lots that refused to sell, and offered expert advice and networking for securing additional
funding, including applying for federal grants and technical expertise from planners and
architects. Finally, H.E.A.L. sought to erect training centers and housing for the medical
professionals and students the district would attract as it expanded.

The creation of H.E.A.L. reflected several important threads in New Orleans's
medical history. H.E.A.L.'s vision of—in the words of Tulane representative Darwin S.
Fenner—"a medical complex second to none in the nation," matched the rhetoric of
Fenner's ancestor E.D. Fenner in the 1850s, C.C. Bass in the 1930s, and other proponents
throughout the city's history of New Orleans as a leading medical center in the United
States. As was the case in these earlier promotions of New Orleans as a medical center,
advocates held up the economic benefits of a strong health care system. In the past,
proponents promoted health care to protect and expand the city's leading industries—the
slave trade and the slave-based economy in the antebellum period and the commercial
trade with Latin America and tourism in the early twentieth century. By the 1960s, the
health care economy itself had become a booming industry, employing thousands of New
Orleanians. H.E.A.L. would further the growth of this burgeoning field by adding an
estimated 2,500 jobs and thus boost the city.
Proponents also wrapped their arguments for H.E.A.L. in the language of urban renewal that marked a deeply ironic switch of many white city and state leaders on federal involvement. After the federal government ordered desegregation of schools following the Supreme Court's *Brown v. Board of Education*, the Louisiana state legislature passed laws that banned the state and municipal government from participating in federal government programs or receiving federal funding; this included urban renewal grants. The state maintained these stipulations until the late 1960s, over the objection of Black proponents who advocated for participation in President Lyndon Baines Johnson's "Great Society" programs. The ban on urban renewal funding protected New Orleans from large-scale scourges of urban renewal that decimated Black neighborhoods in cities throughout the country. When Louisiana finally lifted the ban on urban renewal, New Orleans belatedly carried out several projects, including the building of the 1-10 overpass on Claiborne Avenue in 1968. Originally planned for the French Quarter, the opposition of white business and home owners led the city to place the overpass on Claiborne Avenue in Treme, which contained New Orleans's largest concentration of Black businesses, and the longest line of oak trees in the United States.\(^{473}\) The city also displaced hundreds of other Black residents and businesses for a new City Hall complex and jail in the Tulane Gravier neighborhood, and the Theatre for Performing Arts and Louis Armstrong Park in Treme. The proposed medical complex was part of this push for urban renewal. In April 1970, H.E.A.L. signed a contract to work with the city's Community Improvement Agency which administered the city's urban renewal project. This occurred after 3-2 vote of approval by the C.I.A., with the

two Black members of the executive board voting to oppose the venture. With this partnership, H.E.A.L. and the C.I.A. would carry out urban renewal for a proposed 289 acres, with 30 acres for the medical complex, and the rest redeveloped for housing and other facilities.  

H.E.A.L. reflected the continuing power of the apartheid health care system. No African Americans served on the appointed board of directors or as representatives. Beyond the board members, the potential beneficiaries of H.E.A.L. were also part of the apartheid health care system. In addition to Charity, LSU, and Tulane, the legislature designated the Veteran's Administration Hospital, Hotel Dieu, and the Ear, Eye, Nose, and Throat Hospitals as potential recipients, all located in the medical district. Forced out of the neighborhood decades earlier, Flint Goodridge was ineligible to receive the badly needed funds. The legislation authorizing H.E.A.L. stated that the authors intended it to "promote the health and welfare of its citizens." However, the participants in H.E.A.L. would continue to face complaints—including those previously detailed lawsuits, and federal investigations in the following two decades for discrimination against Black patients and employees.

With the adoption of the H.E.A.L. legislation and the creation of the board, the organization turned to acquiring property. In an effort designed to cause the same displacement of Black families that justified "slum clearance," in the 1930s in Central City and in the medical district, the state again turned to federal funding in the 1970s, this time in the form of HUD grants. To apply for these grants, H.E.A.L. had to secure approval by the City Council before submitting their applications. H.E.A.L.'s

representatives and its proponents made several arguments. They highlighted several economic benefits, including the direct gain creating the projected 2,500 new jobs, and the indirect benefit of using the medical complex to attract large companies to the city. They noted that Louisiana had a shortage of physicians that could be addressed with expanding the medical schools. Finally, they touted the health benefits for all residents of the expanded health institutions, and the opportunity to "improve" the Tulane Gravier neighborhood with urban renewal. J. Jefferson Bennett also stated that residents would not be displaced, as opponents claimed. He argued the medical complex and the urban renewal project would have a "beneficial impact on the residential areas" and have no "detriment to the families and businesses occupying the area." A powerful coalition backed Bennett and H.E.A.L. Mayor Moon Landrieu, who called the project a "fantastic opportunity for the city"; the executive director of the C.I.A.; the chancellor of the LSU system; the president of the Greater New Orleans AFL-CIO; the president of the Chamber of Commerce; the bishop of the Roman Catholic Archdiocese of New Orleans; and the vice president of the Urban League, all spoke in favor of H.E.A.L.'s proposal at the December 1970 City Council meeting.

Dwarfed in terms of civic and political clout, members of OTAGNO spoke against the plans, arguing the project would use taxpayer funds to benefit private institutions like Tulane and "wealthy landgrabbers," while displacing hundreds of Black residents and business owners. OTAGNO President James Comiskey implored the City Council to oppose the measures: "I hope you will stay with me and the people against the millionaires." John Dowling stated it was "unconceivable" that properties in the neighborhood were considered "slums," claiming H.E.A.L. assessment of the
neighborhood as containing many "substandard" structures in need of clearance was false. Other members of OTAGNO argued that the free market would be better in developing the neighborhood than government-sponsored urban renewal. John Campo, owner of the Ramada Inn, told the council: "I'm only in favor of one thing, free enterprise. I'm opposed to expropriation." 475

Casting their support behind urban renewal, the City Council approved H.E.A.L.'s two initial grants. The first for $480,000 was to study the proposed area of the medical complex, examining blight, need for housing, the capital fund requirements, and the needs for medical and supporting facilities. The second was a $3.8 million dollar grant to redevelop the first four acres of the medical complex. H.U.D. approved the grants in 1971. H.E.A.L. prepared to apply for a Neighborhood Development Program urban renewal grant through HUD. NDP's primary goal was blight abatement, with grants to local governments for improvement and clearance projects. The new grant would fund clearance and redevelopment for an additional 114 acres, with plans to apply for future grants to fund the redevelopment of the remaining 172 acres in the area. At the time, residences containing 250 families—215 Black and 35 white—occupied 245 dwellings in the 114-acrea targeted by the NDP grant. The grant identified 233 of the units as having "deficiencies." Despite the earlier promises that they would not displace residents, H.E.A.L. would use their eminent domain power to remove those families—over their objection—and redevelop the properties. They also planned to remove 79 Black-owned businesses. In addition to the general objective of "abatement of blight," the applicants also highlighted the second NDP objective "to expand and solidify an economic base for

the total city which will encourage further development of those areas surrounding the NDP project." H.E.A.L. projected that the medical complex would create 900 full-time positions for low and moderate income New Orleanians, with preference going to the residents of Tulane Gravier. H.E.A.L. also noted in their application that they had formed a Project Area Committee featuring property owners and some tenants of Tulane Gravier—with their inclusion only after protests from OTAGNO over not being included in the process—as well as representatives from the hospitals, medical schools, and other direct beneficiaries. While heavily tilted in composition towards proxies for the involved medical institutions, the application stated the committee was "representative." The H.E.A.L. application addressed the displacement of the 250 families, which were 86% Black. H.E.A.L. argued that "any minority group concentrations will be dispersed through relocation activities to suitable, safe, and standard living conditions throughout the area," a dubious claim given the decades long effort of excluding African Americans from the most desirable neighborhoods and the city-sanctioned placement of health hazards near Black-majority blocks. H.E.A.L. promised not to relocate the families into already-existing minority concentrations, but offered no specifics on where they would end up.\footnote{476}{“Application for block grant from Neighborhood Development Program 1972,” H.E.A.L. Collection, CANOPL.} The application also stated that all the institutions involved in the process "do not discriminate"—despite the fact that all three of the primary institutions—Charity, Tulane, and LSU—and secondary institutions like Hotel Dieu had pending lawsuits and investigations for their failures to comply with federally mandated desegregation and non-discrimination. This cast serious doubt on H.E.A.L.'s claim that the Medical
Complex would provide "extensive opportunity" for employment for low-income residents.

The federal government never approved the application, with a combination of factors playing a role. The lawsuits and federal investigations over discrimination may have led to the rejection, although there is no record of why the federal government denied the application. But it is clear that grassroots activism helped delay the application. OTAGNO again protested against the displacement of the residents and businesses. This opposition forced the city council to temporarily withhold their approval as the two sides negotiated, a necessary step before the application went to a citywide voter referendum. The vote was needed before H.E.A.L. could submit their application to HUD. Although the city council ultimately voted to support the grant, over the objection of the residents, the delay meant the voter referendum did not occur until December 1971 and H.E.A.L. did not submit their grant until 1972. By that period, the Nixon Administration had largely gutted urban renewal and other Great Society projects. If Louisiana had lifted its ban on receiving federal grants earlier, or never enacted it in the first place, or if residents had not organized to oppose the application, then H.E.A.L. probably would have led to the clearance and creation of significant medical complexes that the proponents described as already happening in places like Houston and Birmingham.

Regardless of the project's failure, H.E.A.L.'s application is important to consider as it demonstrates the continual effort to expand the medical district and its pervasive attempts to displace Black residents. It also reveals the government mechanisms and

477 "Board of Governors Meeting minutes," Jan 13, 1971, Ernest "Dutch" E. Morial Collection, ARC.
funding sources that allowed the apartheid health care system to perpetuate post-integration. The effort to create H.E.A.L.'s 1968 vision of a modern medical district would have to wait until post-Hurricane Katrina to be realized, but the effort continued unabated for decades, and H.E.A.L. did help fund the first major step in the 1970s, the creation of Tulane University Hospital.

**Tulane University Hospital**

Although the 1972 HUD grant failed, H.E.A.L. successfully passed a $37.5 million-dollar tax exempt bond for Tulane in 1975 which covered most of the projected $43.4 million cost of their proposed hospital. Beyond H.E.A.L., several other factors greatly aided the university in the construction of the hospital, advantages unavailable to Black medical institutions like Flint Goodridge. Tulane negotiated property exchanges with the city and the state, by trading property they controlled elsewhere in the city—Tulane was one of the largest property owners in New Orleans—for desired property for the hospital and medical school. Tulane gave property to the city in March 1973 in exchange for the latter closing the road on South Liberty Street between Tulane Avenue and Cleveland Street, allowing Tulane to connect the lots it owned there. Thus, the school used its connections and wealth to gain favorable concessions from the city. These gestures stood in sharp contrast to the city's continual use of municipal powers to curtail Flint Goodridge's growth.⁴⁷⁸

The federal government had been helping to fund the medical school since the early twentieth century, with grants to promote medical and public health research through the U.S. Public Health Service Services, the National Institutes of Health, the

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⁴⁷⁸ "Tulane University Hospital Board of Management Meeting minutes," March 28, 1973, Tulane University Hospital Collection, LRCTU.
Department of Health, Education, and Welfare, and other federal agencies. Tulane used these funds not only to pay for research, but also to build or renovate many of their buildings on the main campus and the downtown medical school campus. When Tulane sought to build a new Medical Science Education Building in 1971, they successfully applied for a grant from HEW that covered 2/3 of the projected $25 million cost. Despite its $51 million in endowment, every year, the school received Special Improvement Grants from HEW available to medical schools in "financial distress." Tulane received, $680,000 in 1972 and $865,000 in 1973, due to losses the school reported for raises, rising insurance costs, and reduction in income from Medicare recipients that used their clinics. This ability to apply for federal grants would extend to the new hospital, offering a valuable source of funds that were unavailable to non-university hospitals like Flint Goodridge, which had lost its affiliated medical school with the forced closure of Flint Medical College decades earlier. Due to its prominence and connections, Tulane garnered financial support from its many wealthy supporters. Composed primarily of business leaders, the Tulane Board of Governors solicited millions in donations from their own and other companies and large funding sources. By March 1975, the board reported they had requested funding from 36 organizations and raised more than $17 million in their drive, which was directed by a nationally renowned fundraising consultant group. As a result, Tulane turned down low-interest commercial loans and even a tax-exempt financing offer from Goldman Sachs because these offers were unnecessary due to the influx of donations. While philanthropic groups like the Rosenwald Fund aided the construction of Flint Goodridge's new hospital in the late

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479 "Tulane University Hospital Board of Management Meeting minutes," March 23, 1973, Tulane University Hospital Collection, LRCTU.
1920s, the hospital continually struggled financially, and had no consistent large-scale financial backer after the Rosenwald Fund shuttered in 1943.480

Adding to Tulane’s economic advantage was its development of the hospital in conjunction with a hospital company. In the 1970s, for-profit hospital companies grew, lured by the ever-increasing profits of health care. Companies purchased hospitals, HMOs, nursing homes, and group practices, leading to greater consolidation in ownership of health care. These companies offered financial management and stability for independent hospitals, emphasizing efficiency and cost control.481 Tulane Board members met with representatives from Hospital Corporation of America, American Medical Enterprises, American Medical Corps, and Hospital Affiliates International (HAI). Tulane negotiated with each to secure the best deal, ultimately signing a partnership with HAI in 1972. No such organization was willing to help the management of Flint Goodridge; in fact, the hospital corporation that eventually purchased Flint only did so to take its bed licenses.

Tulane purposely avoided serving low-income patients from its inception. When local health activists approached the hospital about including a badly needed Community Mental Health Center and offered $1.1 million from the National Institute of Mental Health, the board members voted in November 1971 to exclude the project

480 "Tulane University Hospital Board of Management Meeting minutes," March 20, 1975, Tulane University Hospital Collection, LRCTU.
because, stating that "Community Health Centers are financial drains." Tulane hospital initially submitted a bid to take over the services offered by the Public Health Services hospital; however, they ultimately abandoned the idea because, according to the Board, "HEW guidelines, recently received, indicate that Tulane could not receive sufficient revenue," and instead recommended Charity take on the services. When board members met with representatives of HAI in July 1971, they told the company the proposed hospital was a good investment as they would keep "low-income patients at a minimum" by sending any such individuals to the nearby Charity Hospital, a practice known as "dumping" and later declared illegal by Congress. Tulane's stated goal to exclude low-income patients succeeded despite violating the bed quota established under the Hill-Burton Act. Under this formula, New Orleans was already considered over-bedded for the non-indigent population with 3,374 beds in private hospitals in Orleans Parish; and an additional 1,443 beds in Jefferson Parish; 148 beds in St. Bernard Parish; and 885 in St. Tammany Parish. Ignoring these statistics and Tulane's explicit mission, the state granted Tulane Hospital's 154 bed licenses, in the same period that it rejected Hill-Burton funding and additional bed licenses for Flint Goodridge. Little had changed since the Jim Crow period.

482 "Tulane University Hospital Board of Management Meeting minutes," Nov. 17, 1971, Tulane University Hospital Collection, LRCTU.
483 "Tulane University Hospital Board of Management Meeting minutes," March 28, 1972, Tulane University Hospital Collection, LRCTU.
484 "Tulane University Hospital Board of Management Meeting minutes," July 7, 1971, Tulane University Hospital Collection, LRCTU.
485 "Report on Financial Feasibility Study for Proposed Tulane Medical Center Hospital, Clinical Facilities and Parking Garage," Aug. 5, 1972, Tulane University Hospital Collection, LRCTU.
Hospital planners projected that initially only half of Tulane’s patients would come from Orleans Parish, within 1/3 from the greater New Orleans area and 16% from elsewhere. They expected the numbers from Orleans parish to decline and usage from the white flight suburbs to increase. Thus, the hospital they envisioned was not designed to meet the needs of the community, particularly Black residents, as seen in Tulane's low overall patient numbers.\textsuperscript{486} Again, this marked a sharp contrast with Flint Goodridge, an institution that treated mostly low-income patients, many from Central City and other predominantly Black neighborhoods, a majority using Medicare or Medicaid, and all Black. In addition to adding more beds to service an already over-bedded population, critics worried that the hospital would further hurt low-income and minority patients as Tulane, its students, and physicians focused their time and attention on the patients at their hospital, and decreased attention on patients at Charity, therefore depleting the already declining quality of care.

The focus on upper-income, insured, predominantly white patients partially reflected under-representation of African Americans in Tulane's leadership, a vestige of their policies into the mid 1960s. Civil Rights leader and future mayor Ernest Morial joined the Tulane University Medical Center Board of Governors in 1971, as did Henry E. Braden—former chief of medicine at Flint Goodridge—in 1974 after Morial resigned. However, leadership remained predominantly white. In addition to the mostly white board, the administrative council of the hospital and the clinic, the hospital controller; the manager of the credit and collections clinic, the manager of the business office, the director of the business office, the chief accountant, and the entire nursing management

group were all white. After Morial's resignation, outside of Braden, the hospital and clinic had virtually no African Americans in leadership positions. The university's overall governing body, the Board of Administrators, did not have a Black member until 1978, when Braden replaced a resigning member convicted of bribery. The medical school remained predominantly white as well. Despite a 1968 grant from the Macy Foundation to initiate a program to recruit minority medical students, with later funding from the Sloan Foundation, the NIH, and the J. Aron Charitable Foundation Inc., by 1971 the medical school only had seven Black students, and was more than 98% white; the school made gradual improvements but was still more than 95% white in 1974.

Despite some opposition—primarily from the private hospitals threatened by competition from Tulane for upper-income white patients—the state approved the hospital's bed licenses, and the hospital opened in summer 1976. By 1977, revenue already exceeded costs. In addition to "dumping" low-income and Medicaid and Medicare patients at Charity, physicians would also "skim" patients from Charity, taking patients that needed expensive procedures that would result in large reimbursements and transferring them to Tulane so they would reap the profit. Over the next three decades, Tulane University Hospital would prove its planners correct, as it brought in valuable revenue to the University. In fact, only one other hospital, Ochsner Foundation Hospital, consistently made an annual profit in the 30 years leading up to Katrina.

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487 "Tulane Medical Center Newsline #20," Dec. 1977, Tulane University Hospital Collection, LRCTU.
488 "Annual Report of the Office of Medical Admissions," Sept. 1, 1971. Tulane University Hospital Board of Management Meeting March 21, 1974, Tulane University Hospital Collection, LRCTU.
489 "Board of Management Meeting minutes," Sept. 27, 1977, Tulane University Hospital Collection, LRCTU.
Charity Hospital, the de facto Black Hospital

While Tulane University thrived, the other hospital the hospital affiliated with, Charity, experienced a decline similar to that experienced by Flint Goodridge. Ironically, in the same period in which Black patients and employees fought the hospital over discrimination, Charity Hospital became a Black-majority hospital for the first time as white patients left Charity when the hospital integrated. By the end of the 1960s, a hospital which had been 60% white patients in the early 1960s, had more than 75% Black patients. With this switch, state funding decreased dramatically, leading to a 43% drop in hospital interns from 1967 to 1971. Hospital moratoriums on buying needed equipment and repairs, the closing of beds and staff reductions which forced the hospital to away as many as patient, and a general decrease in quality of care exacerbated the situation.\(^{490}\)

By the end of the 1960s, the state had passed legislation, all after integration, which allowed the state to use the already underfunded Charity as a cash cow. One bill permitted the State Department of Hospitals to siphon money collected from surgeries done for injuries incurred during accidents—Charity had one of the leading surgical centers in the state, and would accept money from paying patients for some procedures not available elsewhere—to use for their Research and Training fund. Similarly, the state took half of the money that the federal government allocated in reimbursement for Charity's Medicare and Medicaid patients, and distributed it elsewhere. In 1970, additional funding cuts led to an acute crisis. That May, the hospital closed 454 beds and administrators and state leaders discussed shutting down the hospital altogether. The Human Relations Council, the NAACP, and other civic and community organizations

\(^{490}\) Salvaggio, New Orleans's Charity Hospital, 202.
formed a coalition to secure funding for the hospital. Private hospitals wrote resolutions of support as they feared the closing of Charity would force them to care for indigent patients. The coalition mobilized media attention, had members of the public send letters of support to state politicians, and secured the backing of African American leaders in eighteen parishes. This group also pressured state politicians, organized mass rallies, and wrote their own legislative bills, which they sent to members of the state legislature. Their lobbying efforts led states legislators to introduce five new bills: to give Charity a charitable immunity to lawsuits; to allow Charity to keep all the money allocated by the federal government for Medicare and Medicaid care provided by the hospital; to allow Charity to keep money from other sources like student nurse tuition, fees for legal reports, and soft drink machines; to allow the hospital to keep the money from operations for accidents rather than it going to the state fund for research and training; and a $3 million bond to improve the intensive care areas. The legislature approved all five bills, but funding shortfalls continued in the following decades for the hospital.  

Court Cases and Federal Investigations

By the end of the 1960s, little had seemingly changed in African American access to health care. Most Black residents still used Charity and Flint Goodridge, and the formerly all-white private hospitals stayed mostly white. Tired of waiting for federal enforcement of integration and non-discrimination, residents turned again to grassroots action and litigation over separate blood banks, turning away of Medicare and Medicaid patients, and racial discrimination of patients and employees.

In 1969, the Human Relations Council—an interracial coalition of community activists found that Charity and other area hospitals, including the just-opened Methodist Hospital, still labeled their blood by race. This practice was legal under a 1958 Louisiana state law, despite being illegal under the 1964 Civil Rights Act. The group filed complaints with HEW, but no change occurred. Finally, in 1972, following repeated warnings that the federal government would end all federal funding to every hospital in the state, the state removed the blood labeling legislation.492

In 1970, a group of Black women, aided by the NAACP, the National Tenants Organization, the People's Action Center, and the National Legal Program on Health Problems of the Poor, initiated a ground-breaking case with national implications. The group, with Rosezella Cook as lead plaintiff, sued ten New Orleans hospitals and the Louisiana State Department of Hospitals for violation of Title VI of the Civil Rights, the Hill-Burton Act, and the Medicare and Medicaid Acts. They also sued HEW for failure to enforce the laws. New Orleans area hospitals had refused admittance to the women for acute health problems because they could not pay the admission fee. All were covered by Medicaid, which would have paid the fee and other charges for services. However, in violation of the Medicaid law, all ten hospitals refused to accept Medicaid patients. Additionally, by refusing to provide free care for at least some patients, the hospitals violated the public service provision of the Hill-Burton Act. The women also alleged racial discrimination.493 The resulting case *Cook v. Ochsner*, would linger in the court for

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493 This refusal of treating Medicaid patients led to an inundation at Flint Goodridge and especially at Charity Hospital, resulting in Charity being forced to turn
the next two decades. In 1972, the Eastern District Court of Louisiana found that the Secretary of HEW had failed to enforce the public service provision of the Hill-Burton Act by allowing the hospitals in New Orleans to refuse to admit Medicaid patients. That same year, the plaintiffs and the hospitals reached a consent degree in which the hospitals agreed to begin treating Medicaid patients. However, in 1973, plaintiffs presented evidence that the hospitals had ignored the consent decree, and the District Court found them to be in violation in 1975, although appeals would continue from some hospitals until the late 1980s.494

In 1974, after years of pressure from the NAACP as well as an increasing spotlight as the Cook case wound its way through the court system, HEW finally became involved. HEW's Office of Civil Rights conducted a study of New Orleans hospitals between 1974 and 1977, and it documented the continuation of an apartheid health care system. They found that 75% of all Black patients used either Flint Goodridge or Charity Hospital. Despite African Americans comprising more than 55% of the population in the city, none of the other hospitals had treated more than 15% Black patients. Most of the other hospitals admitted few or no Black patients, and admitted few Medicare and Medicaid patients. Many of the Black patients who used the formerly all-white hospitals were individuals of higher income, including a significant number of those that white doctors brought with them when they ended their affiliation with Flint Goodridge.

Discrimination in hiring in promotion continued as well, particularly with physicians. Most of the hospitals with formerly all-white medical staffs hired few or no Black doctors away as many as fifty patients a day. Institute of Medicine, Health Care in a Context of Civil Rights (Washington, DC: The National Academies Press, 1981), 175.

in the late 1960s and 1970s, and white doctors refused to work at Flint Goodridge. Only one white doctor still served on staff at Flint by 1978. Discrimination extended to other hospital positions as well, with racial sorting of African Americans into lower-paying positions and repeated complaints to the NAACP over mistreatment.

HEW's investigation found nearly every single private hospital to be out of compliance with the law. HEW charged seven hospitals in 1977 and 1978 with violating Title VI of the Civil Rights Act. One hospital settled with HEW, but the others remained defiant. HEW ultimately began procedures against three of the hospitals: Hotel Dieu, Mercy, and Southern Baptist. After the hospitals refused to follow through on a list of actions that HEW mandated, the agency began formal termination proceedings of federal funding in 1978. However, the statute stipulated that an administrative law judge review HEW's findings and then listen to the hospitals' appeals. In 1979, the judge struck down many of the requirements as onerous, including formal recruitment measures. The judge argued the lack of Black physicians in the city made it too difficult to comply with the order. He also characterized the requirement that doctors take Medicaid patients as a condition of staff privileges as “inappropriate,” in the judge's view and the mandated opening of outpatient facilities as too costly. The judge ordered the hospitals to remind physicians and staff that they could not discriminate, urged them to undertake informal recruitment of Black physicians, and consider adding Black board members. With these meek stipulations, he dismissed the termination of federal funds. The NAACP Legal Defense Fund appealed the ruling of the administrative judge and filed contempt charges against HEW for its failure to enforce Title VI. In response, the government set a
timetable for the hospitals to comply with the original demands by HEW, although no real substantive changes or follow-up occurred.\textsuperscript{495}

The \textit{Cook} case led to some formal policy changes and some restitution. In response to the case, HEW quantified the amount of free care—previously not specified—that hospitals that received Hill-Burton funding had to perform at a 3\% minimum for twenty years after receiving the money. In 1979, most of the hospitals involved in the initial \textit{Cook} case settled with the families of those denied hospital admission. The settlement also provided additional Medicaid and Medicare funding for Charity Hospital to open additional beds and hire more nurses. However, some hospitals continued their appeals. It was not until 1989 that West Jefferson General Hospital and East Jefferson General Hospital signed consent decrees—to finally settle the lawsuits brought against them in 1970—to recruit Black physicians and give Medicaid patients full access to the hospitals.\textsuperscript{496}

Despite these settlements, HEW’s failure to require substantive changes or dole out real punishment perpetuated the two-tiered health care. HEW also failed to enforce the new 3\% free care requirement. As a result, white doctors at white hospitals continued to send most poor, Black, Medicaid, and Medicare patients to Charity or Flint.

Ultimately, much like the period a century earlier during the federal occupation of New Orleans, the late 1960s and 1970s proved to be a period in which the possible dismantling of the apartheid health care system did not occur. Lawsuits initiated by Black residents with the support of the NAACP, backed by legislation including the Civil Rights Act,

\textsuperscript{495} Institute of Medicine, "Health Care in a Context of Civil Rights," 182.
forced hospitals to adopt non-discrimination policies. However, the inability or unwillingness of the federal government to enforce compliance allowed the formerly all-white private hospitals to remain predominantly white in both patient makeup and in the physician staff.

It should also be highlighted that like the earlier period, doctors and administrators at the hospitals were the most significant actors in maintaining segregated health care. These individuals purposefully denied entrance to Medicare and Medicare patients, turned away most Black patients (especially low-income ones), discriminated against the Black patients they did admit; and discriminated in the hiring and treatment of Black employees. This outcome—the perpetuation of apartheid health care—was not inevitable. In fact, the fight by civil rights organizations and the court victories and federal legislation should have led to the end of apartheid health care. The purposeful and illegal decisions of administrators and doctors in New Orleans to maintain apartheid health care, partially driven by the monetizing of health care which incentivized health care providers to exclude low-income or indigent patients who provided little to no patient fees, and coupled with the federal government's failure to enforce compliance with the law, allowed the system to perpetuate. As a result, in the decades after the official desegregation of health care, two health care systems existed in New Orleans: private hospitals for white patients, and the underfunded and understaffed Charity and Flint Goodridge Hospitals for Black New Orleanians.

**Grassroots Activism and Federal Programs**

With the two-tiered system's continuation, and the decline in funding, staffing, and services at Charity and Flint Goodridge, the racial health gap widened again in the
post-Civil Rights period. Black residents continued to face negative social determinants of health. Poor quality education made it difficult for Black residents to get jobs. Racial discrimination in employment hiring, wages, promotions, and benefits hurt their ability to get employer-provided health care or the ability to pay for health care costs. Substandard housing conditions, including the underfunded and declining public housing units, combined with poor nutrition to cause a myriad of health issues. So too did environmental racism due to proximity and exposure to health hazards like municipal dumps, industrial pollutants, and lead poisoning, particularly in the public housing units. White violence, police harassment and brutality, and everyday racism also caused health problems. And lack of access to health care meant that many Black New Orleanians could not see a doctor to address these health issues.

All these factors caused significant health problems, as indicated by a 1973 by the New Orleans Department of Health. Black residents suffered from significantly higher rates of maternal death (5.0 per 1,000 compared to a rate of 0 per 1,000 for whites), stillborn babies (19.0 per 1,000 compared to a rate of 8.6 per 1,000 for whites), neonatal morality cases (21 per 1,000 compared to 11.3 per 1,000 for whites); and infant mortality cases (10.9 per 1,000 compared to 4.7 per 1,000 white residents). Problems were greatest for Black residents of Central City, where 10% of houses still had no plumbing. That neighborhood had the highest rates of stillborn children, and infant and child mortality. Over 20% of children in the area were born premature, and the neighborhood accounted for 24% of the city's stillbirths. The Health Department found that many Black children in Central City suffered from malnourishment, anemia, parasites, lead poisoning, diphtheria, and whooping cough. For adults, the rate of tuberculosis was double that of
the rest of New Orleans, and the neighborhood accounted for half of the cases of sexually transmitted infections.\footnote{497 "Letter Doris H. Thompson, Director of Health to Charles Herndon, US Dept. of Agriculture," Aug 10, 1973, NOHD Collection, CANOPL.} Facing these obstacles, and with the continued resistance of the health care system to integration, Black residents built on the work of previous generations and turned again to health activism. In the late 1960s and 1970s, Black residents of the public housing complexes, Central City, Desire, and the Ninth Ward—the areas with the highest rates of poverty, health problems, and least access to health care—formed new organizations to push for health care outside of the hospitals, primarily in the forms of clinics.

Many of the community-based clinics in New Orleans formed under the auspices of federal War on Poverty legislation. Created in 1964 to coordinate the War on Poverty programs in New Orleans, Total Community Action Incorporated identified seven neighborhoods as target areas for distribution of services: Algiers-Fischer, Central City, Desire, Florida, the Irish Channel, the Lower Ninth Ward, and St. Bernard, with neighborhood development centers in each.\footnote{498 Germany, \textit{New Orleans After the Promises}, 64} In addition to coordinating services like employment training, TCA committees—composed of neighborhood residents—pressed the City Department of Health to establish neighborhood medical clinics. In 1969, Central City's Economic Opportunity Committee wrote directly to the Director of the Health Department, Rodney Jung to ask the Health Department for more services at Edna Pillsbury Health Center. The long list illustrated the dire need for attention. He wanted the incorporation of the ideas of neighborhood residents into health planning and the training of residents for work in the health care field. They wanted the placement of a
Black physician, who could "relate with or represent the aspirations and needs of the poor" to serve as a representative on the Board of Health. They also needed weekend immunizations and evening testing programs for workers. They wanted the city to conduct health surveys of parasites, anemia, dental defects, and malnutrition in their neighborhoods. They found that a daily emergency clinic was essential, and they believed that residents trained and hired as sanitation inspectors and health educators could also provide much needed employment. "The time has come," the committee wrote, "when our city and state must provide a better health service if we are to have a healthful community." They demanded a meeting within ten weeks, and threatened protests if the department did not comply. That same year, the Desire Area Community Council also pressed the Department of Health for health services, including a clinic with physicians.499

The neighborhood committees were not the only groups placing demands on the Health Department for clinics to supplement the main health care system. At the public housing units, Tenant Councils—first formed by residents in the 1940s to represent the interest of residents—featured health committees, which carried out projects like working with the Health Department to offer periodic tuberculosis testing and public health education activities.500 In the 1960s, public housing residents demanded permanent health

499 "Letter Evonne Lacy, Gertrude Johnson, and Margaret Tillie to Rodney Jung," April 10, 1969, NOHD Collection, CANOPL.
clinics, particularly as most tenants had no access to a vehicle to drive to a doctor or hospital. Pressure from the councils finally led the New Orleans Health Department to plan to build clinics in Calliope, Desire, LaFitte, Magnolia, St. Bernard, and St. Thomas in 1966. These clinics offered basic medical services, primarily provided by nurses, for several hours during the weekdays. However, the city council's repeated budget cuts to the Housing Authority—which it had done every year since the first move toward integration and the beginnings of the white exodus from HANO buildings—led to most clinics closing in 1970.501

With these looming closures, the public housing councils, the TCA sponsored neighborhood committees, and allied activists and politicians pressed the city to apply for funding from the federal Model Cities Program. Signed into law in November 1966, the legislation gave federal funding to select cities to create new anti-poverty programs. While many whites opposed New Orleans joining the program, the lobbying by Black residents and politicians led the Schiro administration to apply for and receive Model City grants in late 1968.502 Under Mayor Moon Landrieu, from 1970-1973, Model Cities aid funded the building of community recreation centers, helped develop Black businesses, and improved Black participation in the building and construction industries, almost all under the auspices of newly formed predominantly Black organizations and non-profits.503 The largest component of the Model Cities Program funded small clinics in the Desire-Florida and Central City neighborhoods and a full-service health clinic in

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502 Germany, New Orleans After the Promises, 198-201.
503 Germany, New Orleans After the Promises, 203.
Central City, sub-contracted to and run by the Economic Opportunity Corporation (EOC). As described by an organizational pamphlet, the EOC was organized in 1965 "to insure that the Anti-Poverty Program provides the maximum possible participation of residents of Central City and that they best types of services are provided." The EOC formed "Action Committees," comprised of neighborhood residents and designed to "provide an opportunity for them to help themselves through self-help programs," in several areas: employment, business improvement, legal aid, welfare, education, housing, recreation, youth organization, and health and medical services. These committees helped register residents to vote, helped them find jobs, and referred them to social service agencies, among other activities. The health and medical service action committee's self-described mission was "to determine what needed medical services could be brought into the area by existing community resources and what new services need to be created to meet the needs of area residents." Initially, it focused primarily on connecting neighborhood residents to various health programs—including Medicaid and Medicare—and institutions, including doctor's referrals. Under the Model Cities program, the EOC took a more direct role in administering the health clinic in Central City. In 1972, the Family Health Inc.—a non-profit organization started in 1966 by Tulane University's Dr. Joseph Beasley and featuring clinics and family planning centers in Louisiana and Latin America—assumed direct administration of the Model Cities Clinics.

During their four-year tenure, the Model Cities clinics provided health services desperately needed by the residents of the housing units and surrounding neighborhoods,
particularly for acute health conditions and for maternal and infant care. By 1973, the clinics had served 130,000 people, with 49,000 residents receiving outpatient care. Physicians treated 88,000 residents; filled over 125,000 prescriptions; and ran 36,000 lab tests.\textsuperscript{505} Perhaps most significantly, the clinics had refocused after their first year from targeting acute problems to address chronic health conditions: hypertension, glaucoma, anemia, malnutrition, and other long-term problems. With this focus, the sites became badly needed primary care clinics, as most low-income residents could not afford primary care. To do so, the clinics hired internists, pediatricians, dentists, ophthalmologists, counselors, and caseworkers, and provided free transportation for referral services at other health care institutions.\textsuperscript{506} The Model Cities clinics' prenatal, infant, and maternal care provided services previously unoffered by other clinics and only available for patients at Charity Hospital. Similarly, the Model Cities clinics offered the only non-acute pediatric services, and the only dental care outside of Charity.\textsuperscript{507} Encouraged by these successes, African American residents continued to press for further expansion of the clinics. In 1973, the Neighborhood Health Council Concerning Health Services—representing residents of Algiers-Fischer, Carrollton, Mid City, and Treme, all neighborhoods outside of the Model Cities target areas—asked the municipal and state government for support in adding Model Cities clinics to their neighborhoods as well.\textsuperscript{508} However, within months of their request, the clinics would be scaling back services and

\textsuperscript{505} "Memo," April 2, 1973, NOHD Collection, CANOPL.
\textsuperscript{506} "Final Report on Title XIX Special Demonstration Project under Section 1115 New Orleans Model Cities Neighborhood Health Program FY 1973," NOHD Collection, CANOPL.
\textsuperscript{507} "Model Cities Report 1973," NOHD Collection, CANOPL.
\textsuperscript{508} "Resolution of the Neighborhood Health Council Concerning Health Services" 1973, Housing Authority of New Orleans Records, CANOPL.
reducing staff, not adding new locations; within a year, the Model Cities program would end.

The Model Cities program faced numerous problems during its brief tenure. Most significantly, fighting for control over anti-poverty programs like the Model Cities clinics and funding at the various levels and between agencies at the same level caused conflict, confusion, and redundancy. A 1973 study conducted by the Public Development Assistance Foundation found a "complex web" of health programs in New Orleans. The state operated welfare, hospital, mental health, aging, and vocational rehabilitation districts that covered New Orleans, with their own leadership for each various district. At the municipal level, the Department of Health, the Department of Welfare, the Council on Aging, the Community Action Agency, the City Demonstration Agency, the school board, the Housing Authority, and the City Planning Commission all carried out health activities and planning. At the non-governmental level, organizations like the TCA, the neighborhood councils, and the New Orleans Health Corporation all participated in health services. All the various groups administered mostly federally funded health activities and programs, but coordination and cooperation never occurred. Additionally, many hospitals and physicians refused to take referrals for patients from the Model Cities clinics. Although some clinics established official contracts with nine hospitals to deliver babies, they could only offer a small fee for services (a flat fee of $210 dollars), so most physicians refused to participate. Family Health Inc. added financial scandal to their problems, with local, state, and federal investigations of the organization for

510 "Model Cities 1973 Report," NOHD Collection, CANOPL.
misappropriations and bribery starting in 1973. As a result, the government stripped control of the health clinics from Family Health Inc.\textsuperscript{511}

The death knell for the Model Cities clinics came from the federal government itself. In April 1973, the Nixon Administration announced funding cuts for Model Cities. In October 1973, the administration announced that they would not renew funding for New Orleans clinics, and in 1974, it ended the Model Cities program altogether. The non-profit New Orleans Health Corporation took over the significantly scaled-down clinics.\textsuperscript{512} The clinics run by the Department of Health at the public housing units met a similar fate. While tenant councils successfully pressed the Department of Health to reopen and expand clinics in several public housing units in the early 1970s, new HUD rules—ending the rent-free agreement for the clinics and banning further expansion of clinic space in the housing units—and continued budget cuts to Health Department and Charity—which partially staffed the clinics—resulted in the discontinuance of most services and closure of most clinics again in 1972.\textsuperscript{513}

The shortest-lived and most dramatically ended of the community clinics occurred with the New Orleans chapter of the Black Panther Party's Free People's Clinic. The chapter created their health clinic based on the model established by the national BPP in Oakland, initiated in 1970 and recommended for all its chapters. At these clinics, BPP members and volunteer medical professionals offered basic medical—and sometimes dental—services, with a special emphasis on sickle cell anemia testing, an issue the

\textsuperscript{511} Germany, \textit{New Orleans After the Promises}, 205-207.  
\textsuperscript{512} "Letter Terrance H. Duverney to Doris Thompson," April 3, 1973 NOHD Collection, CANOPL.  
\textsuperscript{513} "Letter Allie Mae Williams to Doris H. Thompson," May 19, 1972, Housing Authority of New Orleans Collection, CANOPL.
organization argued that the government and the health care system largely ignored as it predominantly affected African Americans. Chapters also carried out health education workshops at churches, homes, and community centers. Members used their own vehicles to drive residents without transportation to their clinics, and they protested against medical exclusion and exploitation. The New Orleans BPP established their free clinic first at a building near the St. Thomas housing units in May 1970; and then, after the landlord—a white district court judge—ordered their eviction after only weeks of occupancy, at the Desire housing site starting in July. The clinic offered basic medical treatment, booster shots for children, and sickle cell anemia screening, in addition to a free breakfast program that provided free meals for children that year. They also offered classes on self-determination and organized neighborhood clean-ups.\textsuperscript{514}

Although the group dropped changed their moniker from the Black Panther Party for Armed Self-Defense to simply the Black Panther Party a year after their founding in 1966, many whites viewed the organization as militant and subversive. Influenced by the ideology of Black Power, as well as Mao Zedong, Che Guevara, and Frantz Fanon, the BPP advocated anti-capitalist and anti-imperialist ideas, and self-help over government programs. White leaders in New Orleans saw the BPP as a threat. The police chief told Mayor Landrieu that the free breakfast program was a front to "reach young children with their hate philosophy" against the police and the "white race."\textsuperscript{515} The police carried out surveillance of the BPP’s headquarters and attempted to infiltrate the organization. Three weeks after the BPP moved in, the police successfully pressured the landlord to evict the group. A week prior to the eviction date, members of the BPP discovered that two

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\textsuperscript{514} Nelson, \textit{Body and Soul}, 6  \\
\textsuperscript{515} Arend, \textit{Showdown in Desire}, 11.
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attendees at their meeting that day were undercover police officers; after a physical scuffle, the two officers escaped. Sanctioned by Mayor Landrieu, the police announced the following morning they intended to raid the house. BPP members barricaded themselves in the building and refused the order of the assembled force—over 100 local and state officers, plus armored cars—to surrender. The police lobbed tear gas and opened fire, shooting over 30,000 rounds of ammunition in 30 minutes. Somehow, no one inside was injured, and the police arrested 13 members of the BPP. Other members opened a new headquarters in a nearby apartment in the Desire complex. Three weeks later, police and tanks arrived to evict the members which led to a violent confrontation between the police and hundreds of Desire residents who supported the BPP. Police officers shot five residents and burned the BPP headquarters to the ground. Thus, after only several months of operation, the local government ended the BPP's health clinic.516

The Model Cities, public housing units, and BPP clinics provided much-needed health services during their brief existences for many of the city's most disadvantaged residents. The clinics provided not only treatment for acute health problems, but also desperately needed preventative health care. These clinics could have combined with the legally required integration of hospitals to help end the apartheid health care system, and close the racial health gap in New Orleans. However, like period in the 1860s and 1870s when the Freedmen's Hospital and Charity's adoption of a non-discrimination policy opened health care for the first time to many African Americans, the promises of better health services and improved health for Black residents never came to fruition. In fact, in the following decades, Black health would decline. While the mortality gap had nearly

516 Arend, Showdown at Desire, 27.
closed by the end of the 1960s, by the end of the century, Black New Orleanians would again suffer from a mortality rate double that of whites. Chapter eight will explore Black health and health care in the age of crisis.
CHAPTER 8: BLACK HEALTH CARE IN THE AGE OF CRISIS, 1975-2005

Introduction

By 1983, Dr. William Adams had been practicing medicine at Flint Goodridge Hospital for over 54 years. Adams joined the hospital in 1929, when the hospital was still located on Canal St. in the Medical District. He'd stayed with the hospital for its move to Central City, through its early uncertainty, through its successes and expansion, and in recent years, its losses and reductions. Beyond his role as a doctor, Adams became an activist and a leader in the Black community. Mentored in the 1920s by Dr. George Lucas, the first president of the New Orleans chapter, in 1957 Adams became the leader of the New Orleans Improvement Association, an underground organization formed after the Louisiana legislature passed a bill forcing the NAACP and other organizations to turn over membership lists. When the NAACP refused, the state declared the group illegal and forbid it to operate in the state. Adams led the New Orleans Improvement Association's successful suit for the desegregation of buses and other public transportation in 1958, and Audubon Park in 1959.517

In May 1958, Adams testified before the House Committee on Interstate Commerce's hearings on amendments to the Hospital Construction Act. Adams told the body of the many barriers Black doctors faced in Louisiana and his determination to practice in New Orleans and also help lead the fight for equality:

The many restrictions which have been placed upon the Negroes of the state are under attack and your humble servant is now one of the plaintiffs in the bus desegregation case. Although you know that the physician has his hands full, we are trying to put ourselves in line with the community, to see what we can do toward helping to lead our people out of the morass in which they find themselves. We are not compelled to stay in the South. Many of us can practice

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517 Ward, Black Physicians in the Jim Crow South, 289.
elsewhere and some are able to financially able to leave, but we feel that you cannot solve a problem by running away from it, so we tried to stay.\footnote{"Testimony of Dr. William Adams," House Committee on Interstate and Foreign Commerce Hearing on the Hospital Construction Act Amendments, May 5-8, 1958, \textit{Hearings Volume 4} (Washington: Government Printing Office, 1958), 73.}

For over five decades, Adams stayed in New Orleans and remained a fixture of the Black community and of perhaps its most important institution, Flint Goodridge Hospital. He maintained his role as a Civil Rights activist, and helped hundreds of patients.

By 1983, though, Adams warned that he may be finally be forced to leave. That year, Dillard University sold Flint Goodridge to National Medical Enterprises, Inc., a hospital corporation. Dillard made this sale, even though they had twice agreed to sell the hospital to a group of fifty Black physicians, including Adams, who had promised to keep the hospital open. After NME offered more money upfront—although less money overall—Dillard instead pulled out of the deal, and sold the hospital to NME. Adams and members of the staff feared the worst, that NME would shut the hospital down. Adams also feared he may have to move out of New Orleans to find a new hospital that would grant him admitting privileges, necessary to have clients as a surgeon. Beyond these personal concerns, Adams lamented the economic impact of the loss of hundreds of Black jobs in the midst of already increasing unemployment, and the adverse effect on the Black community. "It will have a bad effect on the Black morale because everybody likes to feel like they own something," he told reporters for PBS in February 1983. He believed the hospital's closure would be especially difficult for Black youth who aspired to one day be a doctor at Flint Goodridge. In his opinion, the closing of the hospital would result in "nothing for the Black children to look up to, to look forward to, to say one of these
days I can be part of this thing." As a boy growing up in New Orleans, Adams had that
dream, had that place to look up, and had been part of "this thing" for nearly 20,000 days.
Like Adams predicted, though, those days were numbered. In May 1985, NME closed the
hospital, and distributed its bed licenses to the other hospitals it controlled in the
region. 519

This chapter examines Black health care in New Orleans in the age of crisis, from
the late 1970s until Hurricane Katrina. It explores the factors that led to the decline, sale,
and closure of Flint Goodridge, primarily the hospital's declining finances due to low
levels of reimbursement from Medicare and Medicaid, inability to attract donors or
investors, and lack of government funding. This chapter also explores the growing
corporatization of health care. While Flint Goodridge became a victim of this process,
hospitals like Tulane and Ochsner thrived because they served a wealthier, whiter
clientele and received support from hospital companies and continued aid from H.E.A.L.
Finally, this chapter details the further decline of Charity Hospital, principally caused by
the state's continued reduction in funding. By the 2000s, Charity provided care for 75%
of the city's Black hospital patients, as both quality of care at the hospital and the racial
health disparity worsened.

Flint Goodridge's Decline

Starting in the 1930s, the new Flint Goodridge closed the mortality gap; the
hospital's demise widened it at century's end. By 1977, 56% of patients at Flint used
Medicare or Medicaid. 520 Over the next four years, that figure climbed to 70 percent. 521

519 "Flint Goodridge Hospital," FOLKS, Feb. 6, 1983.
520 "Pamphlet," 1978, FGHCDU.
521 "Minutes of the Board of Management," March 12, 1981, FGHCDU.
Although many continued to use the hospital, the high percentage of patients on Medicare and Medicaid plummeted revenue. In particular, elderly Medicaid patients required lengthy stays in the hospital—tying up beds—and often needing expensive procedures. Every year of the 1970s through until its final closure in 1985, the Board of Management reported that actual cost of care for Medicaid and Medicare patients far exceeded the amount of compensation distributed by the government. In response, administrators attempted nearly annually to negotiate with the government to increase the compensation amount. Although often successful in gaining modest increases, the increased amounts still did not meet the costs to the hospital. Additionally, because every patient's case required an individual claim, approved payment to the hospital occurred months after the actual expense, if at all. Often, claims became bogged down in bureaucratic wrangling or rejected by the government. Thought of as the lifeblood to unprecedented expansion of the hospital in the late 1960s, Medicare and Medicaid instead financially bled the hospital dry. By 1981, the hospital reported that the government owed them an estimated $600,000 for unpaid or partially paid claims.522

The use of the hospital primarily by Medicaid and Medicare patients also further stigmatized the hospital. Ironically, the 1969 expansion report noted the worry that many Lower Ninth Ward residents—primarily low-income or working class—would not use the hospital because they had an "image of our institution as being concerned only with middle-class needs."523 Few in the city would make this claim by the mid 1970s. Indeed, the 1977 report by HEW's Office of Civil Rights noted that most New Orleanians thought

522 "Minutes of the Board of Management." March 12, 1981, FGHCDU.
523 "Expansion Report," 1969, FGHDCU.
of Flint—and Charity—as the "hospitals for the poor." Other factors hurt the hospital as well, such as the declining reputation of care as the institution's dire financial situation prevented the acquisition of needed equipment and kept staff numbers low. The declining reputation of the surrounding neighborhood, as the Magnolia Projects became infamous for high crime and drug use, kept away patients. Patients also faced difficulty in reaching the hospital due to lack of public transportation to Flint Goodridge, desperately needed in a city where many residents—especially the clientele of Flint—did not own a car. Additionally, annually raised fees to offset losses, and competition for paying patients—and nurses—kept patient numbers low. These problems drove away many of the higher-income, paying patients. As noted by physician George Thomas Jr. in a 1986 interview, even though most Black residents wanted to sustain the hospital, "nobody wants to make the sacrifice…they don't want to put themselves at risk to support Black institutions."

The hospital carried out several measures to cut costs and increase revenue. They rented out properties they owned and sub-contracted food and laundry services. In 1971, the hospital closed the outpatient clinic and reduced spending and staff for the emergency room. In 1972, they closed the third floor and seventeen total beds, followed by the closure of the child care center in 1973. The hospital began replacing full-time workers with part-timers and further reduced each department to "absolutely necessary personnel." Still short on funding, the hospital began borrowing hundreds of thousands

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524 Institute of Medicine, "Health Care in a Context," 176.
525 "Report," Nov. 22, 1975. FGHDCU.
526 "George Thomas Jr. Interview," 1986, George Thomas Jr. Papers, ARC.
from local banks at high interest rates and unsuccessfully applying for more federal grants. None of these measures made a significant impact.\textsuperscript{527}

The hospital tried to meet its three main goals. To address its first goal of training Black medical professionals, Flint Goodridge served as a medical training center for students of Meharry Medical College and Dillard's registered nursing program. The hospital also started new partnerships with several local programs. They offered experience for a licensed practical nursing program with the Orleans Parish School Board, Delgado Junior College's radiology program, the Tulane School of Public Health and Social Work, and Xavier University's Pharmacy in the 1970s and 1980s. Through these programs, Flint Goodridge provided invaluable opportunity for Black medical professionals, still severely underrepresented in the health care field in the 1980s.

To address its second goal of addressing public health issues, Flint Goodridge tackled problems that particularly afflicted the Black community in the period. In 1971, the hospital began offering weight loss clinics to address issues like diabetes and hypertension. In 1972, they partnered with the federal government to offer screening and education on sickle cell. In many ways, Black New Orleanians needed the hospital more than it had in decades, as white flight drained municipal resources, and deindustrialization and the oil bust of the 1980s drove up rates of unemployment and poverty, with an accompanying rise in health problems.\textsuperscript{528} With 58% of families living below the poverty line, Central City proved to be perhaps the hardest hit neighborhood, and Flint's leaders argued that the hospital "must re-establish itself as a needed

\textsuperscript{527} "Board of Management Minutes," March 24, 1969 and Sept. 4, 1979, FGHCDU.

\textsuperscript{528} "Report," Nov. 22, 1975. FGHDCU.
community center" in an area "characterized by unemployment, underemployment, lack of quality education and training; inadequate housing, social services, health facilities, and plagued by drugs and crime." Ultimately, the community outreach and public health initiatives of the period paled in comparison to the hospital's efforts in the 1930s, 1940s, and 1950s, which were limited by the hospital's deep financial woes.529

The hospital's ability to reach its third goal, traditional hospital care for as many Black patients as possible, gradually withered. From a high of 164 patient beds in the early 1960s, budget shortages led the hospital to cut the number of beds to 81 by 1980. Flint Goodridge was operating on fumes. The hospital owed over $500,000 to vendors, over $600,000 to Dillard, nearly $400,000 to the IRS, and hundreds of thousands to local banks.530 Financially burdened by the hospital's mounting debt, Dillard University's leaders decided to permanently end their affiliation with the hospital in 1981 and sell the hospital. Initially, Dillard struck a deal for $1.5 million with Doctor Hospitals Group, Inc., a group of 50 local Black doctors that planned to keep the hospital open. Dillard reneged on the deal after Humana offered $2 million, but renewed their agreement with Doctor Hospitals Group, Inc. in April 1982 when they increased their bid to $3.2 million dollars, with $2 million up front and $500,000 due within six months. Representatives of the group told the Times Picayune that although they planned to convert the hospital to a "for-profit" model, they would continue operating Flint Goodridge as a "patient-care oriented" facility and keep the hospital as the "base for Black medicine in New

529 "Position Memorandum," July 21, 1972, FGHCDU.
530 "Letter Quillie Parker to Henry Whyte," June 16, 1981, FGHCDU.
Orleans." Dillard University President Samuel Cook told the *Louisiana Weekly* that ten other groups had submitted higher bids, but the school chose Doctors Hospital Group, Inc., because their "main concern was to keep the hospital in the community." The other groups, Cook detailed, were primarily interested in acquiring the bed licenses and transferring them to another hospital. Despite this pledge to keep the hospital in the community, Dillard again voided the contract when the University demanded Doctor Hospitals Group, Inc. immediately pay the $500,000 dollars originally agreed due in six months. Only able to raise $300,000 dollars—from the physicians themselves—Dillard cancelled the contract in June 1982. The two sides began negotiating again in October, but instead Dillard sold the hospital in January 1983 to National Medical Enterprises, Inc. (NME), a medical conglomerate with more than 40 hospitals nationwide, for $1.8 million dollars. NME already owned five hospital in New Orleans and was building a medical center north of the city. Other national hospital chains also sought to purchase the hospital due to the hospital's state license for 128 beds—highly valued as the excess of beds in the city made acquiring a license for additional beds difficult. National Medical Enterprises senior vice president Gerald Stevens stated that among "different avenues" the company was considering leasing the hospital to Black doctors "so they can continue the heritage." For three years, the hospital hung in limbo, with minimal staff and a small operating budget. The staff of Flint fought to keep the hospital open, contacting local physicians and emergency rooms to ask them to send their patients to the hospital, and

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531 "Hospital's Fate Hinges on Bid by Black Doctors," *Times Picayune*, July 4, 1982.
servicing the community with health fairs where they provided free vision, hearing, sickle cell, and diabetes testing. 

In April 1985, Doctors Hospital Group made a final offer for the hospital, reaching an agreement with NME to buy, renovate, and operate the hospital for $4.2 million dollars; as happened earlier, though, NME backed out and in May 1985 they shut the hospital down. NME's leadership argued that declining admission numbers made running the hospital financially unfeasible; critics claimed NME never invested enough money into the hospital. NME transferred the bed licenses to other hospitals they controlled. Ninety years after first starting as the one-room Phyllis Wheatley Sanitarium, Flint Goodridge Hospital permanently closed its doors. Unsurprisingly, the sale caused controversy in the Black community. President Cook defended the deal. Cook cited the reason as primarily financial, although he admitted the hospital had actually made a profit the last couple of months before the sale. Cook argued the financial losses resulted from several factors. Desegregation of the city's formerly all-white hospital drew away upper-income Black patients. The high number of Medicaid and Medicare patients—90% by the 1980s—diminished patient fees. Cook also argued that "tragic mismanagement" and "financial irregularities" by the hospital's administrators further drained the coffers. Cook claimed that Dillard held on to the hospital "for sentimental reasons" despite losses and that although Dillard had made "concessions" during 20 months of negotiations with the Black doctors' group, their offers had not been "serious." Cook also attributed the hospital's demise to "the loss of broad of community support," blaming Black residents

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534 "Board letter to all physicians," Nov. 21, 1984, FGHCDU.
535 "Letter David Golden to Sidney Barthelemy," May 1, 1985, Councilman Sidney J. Barthelemy Subject Files, CANOPL.
for not further using or contributing to the hospital: "If the Black community is not willing to pay the price to support it, and if the Black doctors aren't going to put patients in, what can we do?" Although "painful" to let it go, Cook argued that the effect on the Black community would be "more philosophical and psychological than practical." Others vehemently disagreed. Keith Butler, a local investment banker who attempted to aid the doctors’ group in raising money, told the *New York Times* that the sale was "part of a continuing pattern, a demolition of minority businesses that once thrived in the deep segregated South." Group member Dr. Dwight McKenna argued the failed bid "spelled the death knell for Black medicine in this community." He continued, “Big dollars are at stake. That's what it's all about: money, as well as jobs, dignity and the right to practice medicine in an environment where you have some clout. Obviously, hospitals make money or the big national companies wouldn't be buying them. Medicine is the biggest business in America today." In many ways, Butler proved correct. Flint Goodridge's closure proved to be part of the "death knell for Black medicine," not just in New Orleans, but throughout the country as many Black hospitals shut down. Between 1961 and 1988, 49 Black hospitals closed nationwide, most the victims of the same problems that plagued Flint; Flint was one of seven Black hospitals closed in 1985 alone.

**Corporate Health Care**

What befell Flint Goodridge Hospital reflected the larger two-tiered health care system. While Black hospitals like Flint Goodridge and public hospitals like Charity

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struggled to remain solvent, private, corporate hospitals prospered. A 1984 study found that investors earned a return of 25% on hospitals.\textsuperscript{539} By 1980, corporations that owned multiple hospitals controlled 30% of hospital beds in America, and the numbers increased in the following years.\textsuperscript{540} Many of the companies adopted a "polycorporate structure," with a parent company owning hospitals to maintain their tax-exempt status but owning other for-profit ventures.\textsuperscript{541} Beyond hospitals, companies invested in other health care ventures like nursing homes, and the newly formed HMOs and PPOs, which were backed by the Nixon administration. Hospitals attempted to create "integrated delivery systems" by buying suburban hospitals and private practices, with physicians at those facilities referring their patients to the main hospital where they received specialized care.\textsuperscript{542} Independent hospitals increasingly turned to hospital companies as federal funding decreased and costs increased—driven by rising prices for medical equipment and new technology. Others unable to secure hospital company support closed. As a result, the number of hospitals declined 17% nationwide from 1980 to 2000. In the 1990s and early 2000s, surviving independent hospitals turned to local hospital systems through mergers to compete with the larger medical companies.\textsuperscript{543}

New Orleans experienced these shifts in the health care field, including the growing presence of hospital companies. This could be seen not only in HAI's investment in Tulane University's hospital in the early 1970s, but also in hospitals throughout the

\textsuperscript{539} Starr, Social Transformation of Medicine, 428; Stevens, In Sickness and In Wealth, 334
\textsuperscript{540} Starr, Social Transformation of Medicine, 430.
\textsuperscript{541} Starr, Social Transformation of Medicine, 434.
\textsuperscript{542} Starr, Social Transformation of Medicine, 464.
\textsuperscript{543} Starr, Social Transformation of Medicine, 464.
city, which became increasingly owned by large hospital corporations.\textsuperscript{544} By the 2000s, national hospital companies Universal Health Services and Tenet, and regional companies like Tulane/HCA, and Ochsner owned most of the hospitals in the area. These companies benefitted greatly from public-private partnerships and arrangements, primarily in the form of tax-exempt bonds to build new hospitals. Other hospitals created their own hospital systems in New Orleans. In 1990, the Board of Trustees approved the establishment of the Touro Infirmary Foundation. In 1994, Touro formed its own HMO. Touro continued to operate as its own entity, occupying increasingly large swaths of what had become known as the Touro neighborhood in uptown.\textsuperscript{545}

The funding from H.E.A.L. allowed both Tulane and Ochsner to grow significantly. Through H.E.A.L., taxpayers funded not just the hospitals themselves, but the infrastructure that supported the hospitals, and indirectly the resulting gentrification of the surrounding areas. H.E.A.L. passed tax exempt bonds of $3.3 million in 1973 for Tulane's hospital to build a parking deck, $31.3 dollars for an expansion of the hospital in 1985, and $9.8 million in 1998 for expansion of the parking deck. In 1995, H.E.A.L.

\textsuperscript{544} In 1972, Lifemark Corporation bought St. Claude General Hospital; in 1973, American Health Services Inc. bought DePaul Sanitarium; in 1977, HCA opened the Lakeview Regional Medical Center in Covington; in 1982, the Tenet Healthcare opened Doctors Hospital of Jefferson; in 1984, Tenet opened Meadowcrest Hospital in Gretna; in 1985, Tenet opened St. Jude Hospital in Kenner; in 1995, Tulane merged with HCA; in 1996, Tenet purchased the Eye, Ear, Nose and Throat Hospital, and Mercy and Baptist Hospitals—the two had merged in 1990 to form Mercy Baptist, and with the acquisition by Tenet, Mercy became the Lindy Boggs Medical Center and Baptist the Memorial Medical Center; in 1997, Tulane/HCA acquired DePaul Hospital; in 2003, United Medical Corporation purchased Bywater Hospital; in 2003, Universal Health Services acquired Pendleton Memorial Hospital; in 2004, Universal Health Services bought Lakeland Medical Center; in 2004, Tenet sold Doctors Hospital of Jefferson to East Jefferson General Hospital; and in 2005, Lakeside Hospital for Women in Metairie and Lakeview Regional Medical Center in Covington merged with Tulane/HCA.

\textsuperscript{545} Peter Wehrwein, "Diary of the Birth of an HMO," \textit{Managed Care}, July 1, 1997.
issued a $56.2 million bond to expand the Ochsner Medical Foundation Hospital. Not only outside of the Medical District, the hospital existed just outside of city bounds in Jefferson, and had no connection to the proposed New Orleans Medical Complex. Nevertheless, H.E.A.L. justified the tax-exempt support of the private hospital as an economic boost for the region, as Ochsner projected to add 880 new jobs, as well as bring in an estimated 144,000 new patients from outside of the area. By the early 2000s, Ochsner had become the region's largest medical system and the area's biggest employer, with more than 7,000 employees. However, while both hospitals created large numbers of jobs, as acknowledged by H.E.A.L., most of the higher-wage, high-skilled positions went to individuals from outside of New Orleans. While this brought in some higher-income residents, many chose to live in the suburbs, bringing tax benefits primarily to white areas. In contrast, as noted by H.E.A.L., the "less skilled tend to come from the local community." These low-paying jobs offered salaries comparable to domestic or service sector work. Additionally, to accommodate the physical expansion of the hospitals, the local governments paid for expanded municipal services, but received no direct tax benefits from the hospitals due to their tax-exempt status. The clientele at both hospitals remained predominantly white, upper-income individuals, many from outside of the New Orleans area.

The Widening Gap in the Two-Tiered System

While these two institutions thrived, and the New Orleans's health care economy grew, buoyed by decisions of the Nixon administration that set up the profitable health sector, the gap in the two-tiered health care system widened. In the 1980s, the Reagan

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administration began gutting New Deal and Great Society programs aimed at helping those in need, exacerbating the differences in the two-tiered health care system. As problems worsened for low-income residents, hospitals that served Black patients shuttered in the period. Two served limited clientele: the Illinois Central Railroad Company closed their employee hospital in 1970, and the federal government closed the Marine Hospital in 1981 due to budget cuts, A significant loss occurred with the shuttering of Bywater Hospital. Started as a small, private, whites only hospital in the Bywater neighborhood in the 1940s, the owners sold the hospital to Lifemark Company in 1972, as the neighborhood become predominantly Black with white flight. In the 1970s, the hospital was the closest hospital for the mostly Black residents of St. Claude, the Upper Ninth, the Lower Ninth Ward, and the increasingly Black majority Bywater. In 1982, Lifemark closed the hospital and converted it to a private drug rehabilitation center to make a larger profit.  

As these hospitals shuttered, Charity and the Department of Health's remaining clinics treated even more low-income, African American residents, even as these clinics too declined. While residents and tenant councils pressed the city for more clinics, budget constraints—driven largely by the city’s shrinking tax base due to white flight—forced the Department of Health to operate the existing clinics as "multi-service centers" that covered multiple neighborhoods. This presented problems, as many low-income residents had no access to a car and New Orleans had an underdeveloped, underfunded public transportation system. The Health Department noted that "geographical distance and

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inadequate transportation" to clinics and Charity Hospital worsened health problems, as it "resulted in neglect of simple health problems with attention being given only to severe and acute health needs as they present themselves to the hospital." In 1975, the Health Department estimated that 92,000 people lived in service areas of their "multi-service centers." The 95% Black clientele had an average median family income of $3,140 dollars. Only 15% could even partially pay for medical care. The NOHD envisioned these service centers as the main entry point into the medical system for the residents. They would provide basic primary care, with consultation and further care provided by Charity, as well as 100 private physicians that would receive reimbursement from the NOHD.

Budget constraints and other problems would limit implementation of this program. When Dutch Morial became mayor in 1978, his transition team conducted a study of the New Orleans Health Department and found a deeply troubled agency which was "not a modern department." Structurally, the NHOD suffered from deep fragmentation and a poorly designed administrative base. The agency had little to no liaison with other health-related agencies or the private health sector. In the area of personnel, the NOHD faced understaffing due to low salaries impacting the ability to fill vacancies. Budget constraints severely limited the agency's capabilities. The NOHD relied upon federal funding for 90% of its budget, and increasing cuts under Nixon—and later Reagan—devastated the agency. In client services, the NOHD offered no health education or preventative services, and the services it did offer duplicated many of those...

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548 "The Community Development Plan," Feb. 13, 1975, NOHD Collection, CANOPL.  
549 "The Community Development Plan," Feb. 13, 1975, NOHD Collection, CANOPL.
provided by Charity Hospital and the remnants of the New Orleans Health Corporation clinics. Jurisdictional and financial limits prevented the department carrying out rodent control in the infested public housing units. Morial's team rated the NOHD programs overall as "low quality." Unfortunately, the NOHD had little data gathering and evaluation to improve services or reduce redundancy. Morial's team made several recommendations to improve the NOHD. Among multiple ideas, they suggested modernizing and restructuring the department, and improving coordination with other health-related groups. They also advocated for improving the city's health care for the prison population, better coordination and quality of care of mental health activities, and restarting the immunization program through the school system.\textsuperscript{550}

Little changed in the ensuing years. In fact, the Health Department's services declined substantially over the next three decades. The budget problem proved to be perhaps the most significant and continual issue. As tax revenue declined in the 1970s and 1980s with white flight to the suburbs and economic recessions, city funding decreased, increasing reliance on state and federal funding. However, the state budget also suffered, cutting their support, and federal funding varied under presidential administrations, with deep cuts under Reagan. The 1984 NOHD Budget Cost Report Summary noted that cuts in funding led to reduction in lead poisoning analysis and increased waiting times at clinics due to layoffs.\textsuperscript{551} The 1985 NOHD budget statement to the city council predicted a "bleak financial future." The department noted decreased city, state, and federal funding even as the NOHD had taken on more programs. "It appears

\textsuperscript{551} "NOHD Cost Report Summary," July 1, 1983 through June 30, 1984, NOHD Collection, CANOPL.
that the point of diminishing returns is near," they stated. "Further cuts will greatly influence marginal productivity due to burnout and stress." At the same time, they noted that residents placed greater demands on the department due to the region's economic downturn.  

In 1986, the state cut funding for Medicaid, AFDC, Food Stamps, placing an even greater demand on the NOHD. Due to cuts they faced as well, the NOHD announced it was closing clinics in Mid City and at the Guste Apartments, as well as reductions in sickle cells clinics, and therefore eliminating 20 positions in the nascent HIV/AIDS program. Cuts in services continued in 1987 for programs for the elderly, TB patients, STI patients, and pest control. Previously under the auspices of the New Orleans Police Department, the city transferred the Emergency Medical Services program to NOHD, even as funding decreased; by 1986, New Orleans had the lowest per capita EMS expenditure of any southern city, with a budget of less than half that of other comparably sized urban centers, and still faced further cuts in 1987. As a result, New Orleans had the slowest emergency response time for any southern city.  

That same year, federal funding for the NOHD reached a low of $899,000 dollars. In subsequent years, federal funding grew, but primarily in the form of grants for new programs. Overall funding declined again in the early 1990s due to state cuts. In 1991, the NODH had a budget of $13.721 million for services for 496,938 people. In comparison, Atlanta's health department budget was $41 million for its 630,000 residents and Baltimore's health department's budget was $103 million for its 750,000 residents.

552 "1985 Budget Statement," NOHD Collection, CANOPL.
553 "NOHD Budget Message 1986," NOHD Collection, CANOPL.
554 "NOHD Budget Narrative 1987," NOHD Collection, CANOPL.
With this funding, in addition to running clinics, the NOHD carried out communicable disease control, HIV/AIDS programs, Medicaid's Screening, Diagnostic, and Treatment Program, lead poisoning testing, services for those affected by homelessness, the Drug Free Program, rat control, hypertension programs, sickle cell programs, and many other programs and services. The NOHD continued to apply and receive federal grants for new programs, but the funding was temporary, and further spread their efforts thinner. The declining city budget offset many of these gains, thus even as the department gained federal and state grants in the mid to late 1990s, it cut clinic staff and services.\textsuperscript{555}

While the NOHD clinics slowly atrophied, Charity closed their system of satellite clinics altogether in the mid 1980s due to state budget cuts. Coupled with the closing of Flint's clinics in the 1970s, New Orleans had virtually no primary care options for low-income residents. "Decisions, personalities, circumstances, failed commitments, dwindling resources and the absence of critical community input and participation all combined to bring the resourceful primary health care era in New Orleans to an end," argued the NOHD. Even when the clinics did operate, they usually referred patients to Charity Hospital for further care. Patients had to then go through the byzantine process of the hospital determining their eligibility, and then go again for a referral, before finally being given an appointment. The time length from the initial referral to actual care was about two months in the 1970s; by the 2000s, it was six months. The 1991 NOHD report's conclusion decried health options for the city's poorest and minority residents: "the current state of health affairs in New Orleans is bleak at best."\textsuperscript{556}

\textsuperscript{555} "NOHD Budget Statement 1991," NOHD Collection, CANOPL.  
\textsuperscript{556} "An Assessment of Need for Primary Health Care Services," May 1991, Mayor Marc H. Morial Papers, CANOPL.
As in earlier periods, some grassroots organizations and non-profits attempted to fill the void. In 1987, the St. Thomas Housing Redevelopment Council—a public housing tenant council—worked with Sisters of Charity nuns to create the St. Thomas Health Services Clinic with some physicians from Ochsner volunteering their services. In 1998, a coalition of local musicians led by the Union of New Orleans Musicians AFM Local 174-96 and faculty from LSU—with support from Tulane, Loyola University's School of Nursing, radio station WWOZ, the Daughter of Charity, the Performing Arts Medicine Association, and several Mardi Gras krewes—established the New Orleans Musicians Clinic on the fifth floor of the LSU Health Sciences Center in the medical district. The clinic provided services for local musicians.\(^557\) However, community-organized clinics and the NOHD clinics could not adequately meet the health care needs of low-income residents. Charity Hospital served as the main health care option for these New Orleanians. When Flint shut its doors in 1986, most patient transferred to Charity Hospital, which was struggling due to the state's repeated budget cuts, and the renewal of the practice of siphoning federal funding intended for reimbursing care provided for the hospital's Medicaid and Medicare patients. The building and equipment deteriorated, with little money for repairs or replacement, leading the hospital to lose accreditation repeatedly throughout the 1980s, and the quality of care decreased significantly.

Charity Hospital's experience in the period reflected the larger struggle of urban public hospitals in the United States, which also treated most cities' minority, low-income, uninsured, and Medicaid/Medicare patients. Many private hospitals "dumped" Medicaid and Medicare patients and patients whose insurance ran out on public hospitals.

like Charity as hospitals focused on making a profit. With budget lines for advertising, larger rooms, more advanced equipment, and better overall conditions, owner-invested hospitals drained public hospitals of paying patients, thus further undermining their precarious financial situation, and widening the already existing health care gap. As a result, those who needed hospital care the most received treatment in hospitals suffering from decreasing quality of care. Many low-income patients, especially the uninsured, used emergency rooms for primary medical care, further draining public hospital resources.\:\:\footnote{558 Anne Osborne Kilpatrick and Lynn W. Beasley, "Urban Public Hospitals: Evolutions, Challenges, and Opportunities in an Era of Health Reform, Journal of Health and Human Services Administration 18, no. 2 (1995): 143-62, 148.}

Federal legislation attempted to address some of these problems, including passing the Emergency Medical Treatment and Active League Act in 1986 which made it illegal for hospitals to "dump" patients, and the expansion of Medicaid eligibility in 1988. However, the practice of patient "dumping" continued in New Orleans, and even with Medicaid expansion, only 19% of residents of the city were eligible for Medicaid in a city with a poverty rate of 28 percent. This mostly resulted from state policy, which kept the maximum income threshold for Medicaid at the second lowest level for any state.\:\:\footnote{559 Dr. Frederick P. Cerise, "Letter to Governor Blanco and Members of the Governor’s Health Care Reform Panel," June 24, 2004, State of Louisiana Department of Health and Hospitals Records, Louisiana State Archives, 2-6.}

Moreover, the NOHD assessed that most residents did not know about their eligibility under the expansion due to a lack of a public information campaign on that or any of the Medicaid services. Additionally, while 1,254 physicians citywide were licensed to offer services for Medicaid patients in 1991, only 58 doctors provided services for Medicaid patients, a reflection of inaccessibility and unwillingness of many physicians to become
involved in Medicaid services. Furthermore, many New Orleanians had no health insurance through their employer. Nearly 21% of residents, predominantly African Americans, had no health insurance at all. Twice as many Black residents were uninsured than whites.

With these conditions, two-tiered health care persisted. Insured, middle and upper-income, mostly white residents, received primary care from private physicians and through HMOs. For hospital care, they used predominantly white, investor-owned, high quality hospitals like Ochsner and Tulane. In contrast, the New Orleans Health Department clinics, community clinics, and Charity Hospital provided care to the uninsured, Medicaid and Medicare recipients, the low-income, and mostly Black residents. New Orleans leaders recognized the existence of this health care divide. In their 1991 annual assessment, the NOHD wrote:

the network of health care services available to citizens of New Orleans is stratified much as the demographics and income indicators suggest. The poor and near poor use free or subsidized services for mostly episodic, rather than continuous care. As a result, much of their health care needs are met in emergency rooms.

The NOHD reported that low-income patients primarily used Charity Hospital's emergency room for health care. Many low-income residents also used the emergency room as their primary pediatrics care; over half of outpatient patients were 13 or under. The heavily reliance on the emergency room for all medical conditions, coupled with reduced staffing due to budget cuts, resulted in an average emergency room wait time of 12 hours at Charity. Low-income African American patients also increasingly used the

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560 "NOHD 1991 Assessment," NOHD Collection, CANOPL.
562 "NOHD 1991 Assessment," NOHD Collection, CANOPL.
emergency room at the Methodist Hospital in New Orleans East. As previously detailed, hospital founders and city leaders envisioned the hospital playing a significant role in promoting the white growth of New Orleans, fostering a white suburb within city bounds during white flight. However, the demographics of New Orleans East shifted in the 1980s as middle-class African Americans seeking a suburban lifestyle moved to the area, and large-scale apartment complexes began accepting housing vouchers for low-income residents. This transition, as well as the loss of higher paying petroleum, port-related, and manufacturing jobs led to a second wave of white flight, as white residents moved to suburbs outside of New Orleans East in the late 1980s and 1990s, making the area majority-Black by 2000. With this shift, low-income residents of the largely isolated East began increasingly using the emergency room at the Methodist Hospital, the only hospital in the area. Between 1988 and 1990, the number of emergency room visits at the hospital grew 16%, and continued to increase in the following years. By the time of Katrina, the former white flight hospital had become the second most used hospital by African American residents.\(^{563}\)

Charity remained the primary source of health care for Black residents. The NOHD reported that Charity admitted 169,397 patients in 1990. Of these patients, 75% were minority, with 67% African American and 6% Latino. The hospital and its clinics had 375,000 outpatient visits. Of this group, over 87% were minority, with 80% Black and 5% Latino.\(^{564}\) With this increased usage, overcrowding, and long waits, a change needed to happen. Either Charity had to expand, or private hospitals needed to accept more indigent and low-income patients. Not surprisingly, the leaders of the city's private

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\(^{563}\) "NOHD 1991 Assessment," NOHD Collection, CANOPL.
\(^{564}\) "NOHD 1991 Assessment," NOHD Collection, CANOPL.
hospitals and the OPMS favored the former. In a 1983 report, the OPMS Charity Hospital Study Committee studied whether the city still "needed" Charity. In a survey of 11 private hospitals in the area, only seven stated that they provided "some care" for low-income residents, and only two hospitals indicated to the OPMS they would be willing to accept more low-income patients if Charity closed. Rather than push these hospitals to take more low-income patients to relieve the burden of the already over-crowded Charity—which had 1,642 beds despite having a "utilizable capacity" of 900 and still continually turned away patients, including for needed surgeries—the OPMS recommended that Charity complex add an additional 1,200 more beds.\(^{565}\) Beyond recommending increasing the number of beds in their 1983 report, the OPMS called for needed improvements: upgrades and renovations of every basic structure, equipment, the emergency room, plumbing, electrical, and sterilization equipment, all described as in "dire need." They also recommended the administrative system be completed "overhauled," as it had "little accountability, low morale, lack of productivity, and no long-range planning." They cited the joint administration by LSU, Tulane, and Charity itself, which "frequently had competing interests," as one of the main issues.

The problems with Charity which the OPMS highlighted in their 1983 report—overcrowding, desperately needed upgrades, administrative issues and in-fighting—did not improve. LSU and Tulane split direct control of the management of Charity, a problematic arrangement. Under their 1974 agreement with the state to run the hospital, the two schools could prevent any programs or activities at Charity Hospital that they

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\(^{565}\) "OPMS Charity Hospital Study Committee Report," Dec. 1983, OPMS Collection, LRCTU.
viewed as counter to their interests. For example, when Tulane established its own hospital, the university directed the revenue-producing research projects it had previously carried out at Charity to its own hospital, and fought to prevent similar research projects from being awarded to Charity, preventing badly needed income for the hospital.\textsuperscript{566}

To counter this problem of administration, in 1989 the state legislature created the Louisiana Health care Authority (LHCA), which assumed control of all nine hospitals in the statewide Charity system in 1991. In their "strategic report" they issued to the state legislature, the LHA identified New Orleans's Charity Hospital's biggest problems, many the same identified by the OPMS eight years earlier. The continuing underfunding had led to reductions in the number of residency slots. Low salaries drove away many of the most experienced employees. Due to understaffing, patients faced long waits for medical procedures. Much of the equipment was outdated or damaged and needed upgrades and repairs. In fact, the LCHA argued that the entire building should have been replaced 30 years earlier. All these issues negatively impacted quality of care.

As if to underscore their point, in 1991 Charity lost to its hospital accreditation due its problems, nearly forcing its closure. In 1992, the LHCA purchased Hotel Dieu from the Daughters of Charity, intending to include it in the New Orleans Medical Center Complex. The LHCA changed the name from Hotel Dieu to the University Hospital, with the intention of using that and not Charity as the main teaching hospital, and announced plans to close Charity within the following five years. In the interim, the LHCA asked the Joint Commission on Accreditation of Health Organizations to allow Charity to continue operating without making improvements the JCAHO mandated to restore the

\textsuperscript{566} Salvaggio, \textit{New Orleans's Charity Hospital}, 241-242.
accreditation stripped from the hospital in 1991, as they estimated the costs of improvements to exceed $20 million. However public backlash over the willingness of the LHCA to allow patient care in a facility deemed unsafe, forced the LHCA to carry out the improvements and the JCAHO restored the hospital's accreditation in 1994. The spending on the improvements also halted the construction of a critical care tower next to the University Hospital, intended to placate physicians at LSU who wanted their own space to treat private patients, mostly "skimmed" from Charity. Ultimately the state legislature rejected the idea of closing Charity Hospital.\(^{567}\)

In 1997, citing poor leadership, excessive spending, the purchase of the Hotel Dieu, and the creation of high-paying "unnecessary" positions for cronies, the state legislature voted to abolish the LHCA, and turned administration of the Charity system over to LSU. LSU reached a partnership arrangement with Tulane to co-administer Charity Hospital. However, both schools focused primarily on their own hospitals: Tulane on the Tulane University Hospital, and LSU on the University Hospital, which they used for their paying patients. Both schools also continued to "dump" low-income patients on Charity and "skim" the high-reimbursement patients from Charity for their own hospital.\(^{568}\) In addition to the problem of dumping and skimming by LSU and Tulane, Charity continued to suffer from state siphoning of its Medicaid and Medicare reimbursement. Congress awarded Disproportionate Share Hospital funding for the statewide Charity system to help offset the costs of providing care for so many Medicaid


\(^{568}\) Roberts and Durant, A History of the Charity Hospitals of Louisiana, 44-54.
and Medicare patients, reaching $4.2 billion dollars annually by 1994. However, the funding did not go directly to Charity Hospital, but rather to the state Department of Health and Hospitals. The DHH reallocated funding to other projects, including for private psychiatric facilities. The state also used part of the funding to pay for budget shortfalls in other areas. Congress passed new legislation to attempt to prevent this practice by the states, and threatened to cut all Disproportionate Share Hospital funding to Louisiana due to its misuse, particularly for the private facilities. Under Republican Governor Mike Foster, Secretary of Health and Hospitals Bobby Jindal negotiated a deal with the federal government to only reduce the funding by $400 million—still a devastating loss which only hurt Charity's patients—and pledged to end the practice of reallocating the funding. However, the practice continued in the following years.\(^{569}\)

By the 1990s, Charity Hospital had become the embodiment of the state's abandonment of the public health care system. Rather than address the hospital's needs which resulted in near perpetual crisis, state leaders and hospital administrators carried out superficial measures that fixed none of the problems. In 1999, the state stripped administrative co-control of Charity from Tulane, blaming the school for the hospital's failures. That same year, a state budget deficit almost resulted in the closure of 15% of beds in 1999, averted only by the influx of money from a state settlement with tobacco companies. The legislature prevented a mandated closing of the hospital due to the missed deadline that year to install fire sprinklers by writing new legislation that gave the hospital until 2005, with funding for the improvements finally occurring in 2002. Budget

cuts from the legislature continued nearly every year, even as the federal government increased DSH funding, with money continuing to be diverted to other projects or budget shortfalls in other areas. These cuts occurred even after the legislature ordered Charity and the other hospitals in the Charity system to assume control of—and payments for—hospital care for prisoners. In 2003, when the DHH diverted $334 million dollars of DSH funding intended for the Charity system, the legislature cut Charity Hospital's funding by $27 million dollars, leading to the elimination of 59 jobs; the diabetic clinic, nine operating rooms, and the W-16 walk-in clinic, which annually provided free ambulatory care for over 40,000 patients.\footnote{Kenneth Brad Ott, "The Closure of New Orleans' Charity Hospital After Hurricane Katrina," (Master's Thesis, University of New Orleans, 2012), 56-60.}

Some emergency room patients from Charity Hospital ended up at the reopened Bywater Hospital. In 2003, a group of local physicians purchased the former Bywater Hospital from Lifemark—still being used a drug rehabilitation facility—and reopened the hospital. From 2003 to 2005, the emergency room at the Bywater Hospital admitted 10,000 primarily low-income, uninsured African American patients, many of whom were residents from the surrounding area. However, due to low finances as an independent hospital, the Bywater Hospital closed in March 2005.\footnote{Franklin, "A New Kind of Medical Disaster in the United States," 186.}

As state cuts further eroded patient care at Charity Hospital, the state and LSU sought to decrease services and patient numbers, rather than restore funding. In 2003, pushed by LSU, the state legislature passed Act 206, which established a new means test for use of Charity Hospital. Patients now had to be below 200% of the federal poverty threshold to receive treatment at Charity. This legislation sled to a slight reduction in
patient usage at Charity, at the expense of care for residents who fell slightly above the cut-off point. Additionally, the bill authorized LSU to cut spending at Charity by up to 35% without permission from the legislature.\textsuperscript{572} By 2004, the average wait time for emergency room services was 12 hours. The average waiting period for an appointment at a clinic was six months.\textsuperscript{573} Despite this, in a survey on potentially closing the Charity system and pooling the money to provide care for the indigent in other hospitals, over 91% of New Orleanians favored keeping Charity Hospital open.\textsuperscript{574}

Increased oil revenues buoyed Charity's budget for the 2004 and 2005. Additionally, the new administration of Governor Kathleen Blanco finally ended the practice of diverting DSH funding, further shoring up the hospital's finances. Nevertheless, LSU continued to push for closing Charity, arguing the conditions at the hospital would lead to the loss of accreditation. The state legislature threatened to decrease funding for LSU if hospital administrators not address the long waiting period and the closure of beds—by 2005, the hospital was down to 700 beds—a situation the legislature partially created through years of diverting the federal DSH funding. Critics lambasted the administration carried out by LSU at Charity, arguing the school was much more focused on providing education and training for their medical students than for patient care at the hospital they administered.\textsuperscript{575} Unperturbed, in May 2005, LSU released a report that proposed closing both Charity and the University Hospital, and building a

\textsuperscript{573} Kevin U. Stephens “Governor’s Health Care Reform: Region 1 Consortium Update,” March 17, 2005, Louisiana Regional Health Care Consortium Region One, 4.
\textsuperscript{574} Marsha Shuler, "Majority Favor Keeping State Charity Hospitals," \textit{The Advocate}, January 12, 2005.
\textsuperscript{575} Jan Moller, "Senators Blast Care at Charity Hospitals," \textit{Times Picayune}, June 3, 2005.
new academic university hospital on Canal Street, despite the lack of political support for the plan. By 2005, African Americans comprised 75% of Charity's patients. Eighty-five percent of patients a year earned less than $20,000 annually, and over half had no medical insurance—other hospitals in the city averaged only 4% of patients without insurance, and combined served 17% of uncompensated cases, compared with the 83% provided for by Charity.

The widening of the gap in the two-tiered health care system had produced a widening of the racial health gap, which had also been exacerbated by increasingly negative social determinants of health for the city's Black population including: low-quality education and high drop-out rates in the underfunded public school system; high Black unemployment—triple the rate of whites—and underemployment as the loss of higher paying port-related manufacturing and transportation jobs were replaced with low-paying jobs in the burgeoning service and tourism sectors; Black median income half that of whites; a Black poverty rate more than triple that of white residents; increased residential segregation and racial concentration of poverty; exposure to health hazards, including cancer causing petrochemical products in "Cancer Alley," and lead in the public housing units; increasing crime, drug, homicide, and incarceration rates; and the HIV/AIDS epidemic. These factors led to high rates of diabetes, heart disease, stroke,

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577 Lincoln, "The History of Tulane University's School of Medicine's Involvement with Charity Hospital." Rudowitz, Rowland, and Shartzer, "Health Care in New Orleans Before and After Hurricane Katrina."
cancer, infant mortality, maternal mortality, asthma, lead poisoning, HIV/AIDS; a rate of mortality double that of whites; and low life-expectancy.\textsuperscript{578}

With Black health and health care at a new nadir by the new millennium, New Orleans desperately needed a radical change. In 2005, Hurricane Katrina would lead to radical shifts in health care, explored in the concluding chapter.

CONCLUSION: BLACK HEALTH AND HEALTH CARE AFTER KATRINA

Introduction

Malik Rahim had been an activist for nearly four decades by August 2005. Born in 1947 in the Algiers neighborhood of New Orleans, Rahim descended from a lineage of activists, including his grandparents who were members of the Universal Negro Improvement Association and African Communities and contemporaries with Queen Mother Moore, the Louisiana-born Civil Rights leader and Black nationalist. Rahim dropped out of high school to join the Navy in 1965. During training in Los Angeles, Rahim became involved with Maulana Karenga's pan-Africanist US Organization. After a tour of combat in Vietnam, Rahim returned to New Orleans in 1967 and helped lead the local chapter of the Black Panthers. With the BPP, he helped run the free breakfast program, neighborhood cleanups, community patrols, and the health clinic in the Desire housing projects. Wounded by police during the afore-described "Showdown at Desire," a jury acquitted Rahim of attempted murder charges. As a community organizer in California in the 1980s, Rahim fought for affordable housing and tenants' rights. In the 1990s he returned to New Orleans where he established a housing and job training program for ex-offenders, fought against the death penalty and to release the Angola Three, and unsuccessfully ran for Congress as a member of the Green Party.579

Rahim's experiences as an activist and community organizer served him well in the aftermath of Hurricane Katrina. A week after the hurricane made landfall in New Orleans, Rahim, Scott Crow, Sharon Johnson, and Ferris Bowles started the Common Ground Health Clinics in Algiers. As told by Rahim in a 2006 interview, the group

579 "Interview with Malik Rahim," Aug. 6, 2015, Joel Buchanan Archive of Black History, University of Florida.
started the clinic to provide care for Black residents abandoned by the federal
government and threatened by armed vigilante groups of whites that refused to let them
cross over the bridge into Gretna:

Right after the hurricane, we came to the realization that the city wasn't going to
provide any services. The first couple of days we was doing rescues, then we
moved into doing relief work, cooking food for the people that was coming
across, trying to feed them, giving them water, I'm talking about those that was
escaping the flooding. Once they walked across the bridge, Gretna, and the
Jefferson Police, and the Jefferson Parish police, would turn Blacks around. If you
was white, you was able to find refuge in Gretna, but if you was Black, you wasn't
able [to] even enter, you couldn't pass through it. They were literally quarantining,
and they would literally tell you, "Take your Black ass back to the Ninth Ward."
We knew that we had to develop some type of lasting mechanism to assure that
everyone that is in need of aid would receive that aid and that we could learn and
develop a mechanism to make sure that this never happened again. So under that
environment of blatant racism and total abandonment by the federal government,
we founded Common Ground. 580

Volunteers rode bikes around the area to see if residents needed care. They found not just
acute issues from the storm, but also widespread chronic health issues afflicting low-
income Black residents. Activists set up the clinic first in a mosque and later in a former
corner store, with Rahim using personal contacts to get physicians to come to New
Orleans to volunteer their services. In the first two months of operation, 4,000 people
visited the clinic. In November 2005, Common Ground became a registered 501(c) non-
profit. The clinic also started providing vaccinations and health services for immigrant
laborers involved in the rebuilding efforts. In 2006, they started the Latino Outreach
Project, which provided a weekly health clinic on in Central City. 581 By the end of 2008,

580 "Interview with Malik Rahim," May 23, 2006, Oral Histories of the American
South Collection, Documenting the American South, University of North Carolina at
Chapel Hill Library.
581 Benjamin Morris, "Latino Health Outreach Project at Common Ground Health
over 1,000 licensed health care providers had volunteered their services at the clinic.\textsuperscript{582}

As iterated by the founding members, the Common Ground Clinic built on decades of Black health activism and self-care in light of official neglect. Rahim traced his experience with the BPP clinic as foundational for starting Common Ground's clinic:

Well, to start a health clinic or a first aid station wasn't nothing, because this is things that we did in the Panther Party. So I knew that after seeing that this city was without health care, that it was something that had to be developed, so it wasn't nothing. I knew that it could be done cause we had health program[s], so it wasn't nothing for me to make a call for health care professionals because I knew that they was out here. I knew the doctor that had been in the Party, working with us in Oakland. I made a call out to her, she called other health care professionals, told me she couldn't come right then but she was gonna make sure that others came. So it wasn't nothing to start the health care program and health clinic that eventually became a health clinic, the first aid station. There's talk about doing mold remediation, there's nothing but a continuation when I sit down with Brandon to start this, of our pest control program. Everything that we did was based upon self-sufficiency, so it wasn't nothing to start or to re-establish, because I knew that it was workable. I could've been in the Ninth Ward doing all kind of things because of the fact that most of the residents, the young adults in the Ninth Ward today, I fed their parents. You know, they came to our breakfast program. They had their first taste of political education through us. Even though they might not remember me by name, "Oh, he was one of them Panthers? Oh yeah, man."\textsuperscript{583}

For Rahim, his experience with the BPP showed that activists could start a grassroots health clinic. Rahim was also able to utilize some of his contacts with the BPP to find doctors to staff the clinic, and establish trust with clientele of the clinic due to the BPP's previous work.

The establishment of the Common Ground health clinic represented many of the both the changes and continuities in health care in post-Katrina New Orleans. As detailed

\textsuperscript{582} Assistant Secretary for Planning and Evaluation, "Role of Faith-Based and Community Organizations in Providing Relief and Recovery Services after Hurricane Katrina and Rita," (Washington, D.C.: U.S. Department of Health and Human Services, 2008).

\textsuperscript{583} "Interview with Malik Rahim," May 23, 2006.
in this chapter, Katrina, or rather the opportunities presented by the disaster, led to one of the most significant changes in the city's history of health care: the shuttering of Charity Hospital. Although ready to reopen just weeks after the storm, LSU administrators chose purposefully to keep the hospital closed in what became a successful bid to finally replace the institution with a modern university hospital. This chapter explores that decision, the process that led to the federal government's funding of the project, and the impact of this transformation, including the loss of access to health care for many low-income, Black residents, and the displacement of hundreds of Black families and businesses to build the University Medical Center as part of the BioDistrict. Akin to previous periods like post-Civil War and Civil Rights years, an opportunity to erase two-tiered health care existed and evaporated. Instead, clinics like Common Ground and others provided care for low-income Black residents, building on hundreds of years of Black health activism. This chapter also explores the roles of federal programs like the federally qualified health centers (FQHC) and the expansion of Medicaid in increasing access to health care, and the factors that contributed to the perpetuation of racial health disparities. This dynamic—of positive improvements by health activists countered by steps to continue two-tiered health care, with the state and federal government often helping fund both elements—proved to be the mark of the decade and a half after Katrina, and the legacy of hundreds of years of apartheid health care in New Orleans.

**Impact of Katrina and the Failure of the Levees**

The inundation of New Orleans from Hurricane Katrina and the failure of the federal levee system led to a severe crisis for the health care system and set in motion a radical transformation of health care. Flooding displaced nearly 4,500 physicians from
the Greater New Orleans area and caused the closure of every hospital in the city, with only three hospitals in the suburbs—Ochsner, East Jefferson, and West Jefferson—staying open.\textsuperscript{584} Although Charity suffered the least amount of flooding of any hospital in the city, flooding in the basement led to the loss of primary power and forced the hospital to rely on diesel generators and hand-pumped devices. For five days, 360 patients and 1,200 staff members waited for rescue, while helicopters hired by the companies that owned the city's private hospitals evacuated those institutions. Physicians brought the most critically ill patients to the rooftop of the Tulane University Hospital parking garage, where helicopters hired by Tenet rescued that hospital's patients and staff. Despite the higher need, Tenet refused to allow the Charity patients on board and instead evacuated all the individuals from Tulane. As stated by Ben DeBoisblanc, chief of Charity's medical intensive care unit: "I saw 100 helicopters land and take off and people walking onto those helicopters ... and fly off while I'm there on the rooftop bagging critically ill patients." At least one critical Charity patient died on the rooftop during the twelve hours they waited. Finally, after a total of five days, army helicopters landed to rescue the critical patients, and a mix of airboats—operated by volunteers and the Louisiana Department of Wildlife and Fisheries—and trucks evacuated the remaining patients and staff. DeBoisblanc iterated the anger and frustration that many at Charity felt about the delayed evacuation: "It's a travesty how this hospital for indigents was being treated."\textsuperscript{585} That anger would only intensify in the coming months and years as LSU officials fought to prevent the hospital reopening. Following the evacuation, military

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\textsuperscript{584} "Study Shows Hurricane Katrina Affected 20,000 Physicians, Up To 6,000 May Have Been Displaced," \textit{Science News}, Sept. 28, 2005.

\textsuperscript{585} Tony Freemantle, "Trapped hospital workers kept most patients alive," \textit{Houston Chronicle}, Sept. 18, 2005.
}
units pumped out the water and cleaned the hospital. An inspection by the Army Corps of Engineers revealed the building to still be structurally sound and ready to reopen in late September. Staff reported to open the building, but hospital administrators ordered them to return home and keep the hospital closed. LSU's leaders claimed that the hospital was unfit to reopen, defying the assessment of the military and the hospital staff. Signaling their intentions, in late September 2005, the Louisiana Department of Health and Hospitals refused to accept $340 million dollars in FEMA public assistance funding from the Department of Defense to carry out repairs needed at Charity. The reasons would soon become clear: LSU's leaders and political allies viewed this as their best opportunity to finally replace Charity Hospital with a new university hospital.586

The forced closure of Charity severely limited the availability of needed hospital beds, and disproportionately impacted low-income residents and those with chronic health problems. With the main hospital closed, staff opened the "Spirit of Charity" clinic, which operated out of a tent first in the Convention Center, then in a mall, and later in a building next to the Superdome. The "Spirit of Charity" provided only limited care, with no services for patients with chronic health problems. Other hospitals took on some of Charity's former patients. Overall, six months after the storm, Greater New Orleans had 1,984 beds in use, down from 4,083 before Katrina. Hospitals. Staffing shortages, especially of nurses, prevented the use of all beds at the still open or recently reopened hospitals. With LSU keeping Charity closed, Touro, which reopened 28 days after Katrina, East Jefferson, and West Jefferson hospitals witnessed significant jumps in use of their emergency rooms as indigent patients that previously used Charity turned to

586 Ott, "The Closure of New Orleans's Charity Hospital," 77-81.
emergency rooms as their only source of health care. Touro, for example, had a 50% increase in emergency room visits in 2006. After Tulane Hospital reopened in February 2006, uninsured patients made up about 12% of patients for the year.\(^5\) The increased number of uncompensated cases led to operating losses for all these hospitals. In response, the state legislature reallocated $120 million previously designated for the Charity system and raised Medicaid rates by 4 percent. West Jefferson, East Jefferson, Ochsner, Tulane, and Touro collectively reported more than $212 million dollars in operating losses for 2005. Special payments from the state and federal government offset much of the expenses for 2006, resulting in a net loss of nearly $29 million dollars for 2006. The following year was worse, as costs increases led to over $145 million dollars in losses for 2007. With Charity still closed, the two-tiered health care system had suddenly changed, forcing suburban and private hospitals to provide significantly more care for low-income and indigent patients and incur the associated losses. However, unlike the state's decades-long pilfering of federal funding intended to reimburse Charity for its uncompensated or undercompensated care, federal and state funding to offset the losses at the suburban and private hospitals passed and spared them financial pitfalls. Additionally, many former Charity patients lacked transportation to Touro—located uptown—or the hospitals in the suburbs. As low-income individuals, many of Charity's patients were the least likely to return to the city from their displacement as many lacked the needed financial resources. These two factors limited the number of low-income and indigent patients at the private and suburban hospitals

assuming some of Charity's patient load.588

In November 2006, LSU finally reopened part of the New Orleans Medical Complex; instead of re-opening Charity, they chose to use federal aid to open part of University Hospital, the institution they had used for their paying patients prior to Katrina. Additionally, instead of the 575 beds in use prior to the storm, the hospital initially only used 85 beds. In February 2007, still operating at partial capacity, the University Hospital assumed the designation as the city's primary trauma center, which was previously provided by Charity Hospital. From nearly 1,300 beds combined between Charity and University hospitals prior to Katrina, the public hospital system operating inside of the city bounds now totaled just 85 beds.589

LSU's refusal to open Charity led to protests and grassroots response. Residents and local activists, including former employees of the hospital, organized and formed the group "Save Charity Hospital." Creating a coalition with other community organizations, the groups tried to pressure LSU to reopen the hospital. Despite public protests, LSU and its allies began pushing for a new university hospital that would replace Charity Hospital and serve as the centerpiece of a medical and bioscience district in New Orleans. Weeks after Katrina, the state legislature passed a bill that authorized the creation of Greater New Orleans Biosciences Economic Development District, a direct descendant of H.E.A.L. Beyond the funding of Tulane University Hospital, Ochsner's expansion, and several smaller projects, H.E.A.L. largely lingered in the years before Katrina. In 1993, a

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group of architects and planners created the Master Plan for the New Orleans Regional Medical Center. The plan created a governing commission, identified partner institutions, formulated funding schemes, and projected job growth and economic impact of an expanded medical and bioscience district. This led to no changes however. In 1999, Governor Mike Foster's administration crafted the Louisiana Master Plan for Economic Development titled "Louisiana Vision 2020." This plan identified the medical field as one of the state's "technology clusters" that would grow and diversify the state's economy, with New Orleans as a focal point. In 2002, New Orleans updated their 1993 plan for the Medical Center, now titled the Comprehensive Plan for the New Orleans Biomedical Research and Development Park. In 2004, the mayor's office of economic development contracted with Greater New Orleans, Inc.—a private, regional economic development organization—to help plan the Biomedical district with representatives from the Downtown Development District, LSU, Tulane, the University of New Orleans, and Xavier University. This contract with GNO Inc. and the name change of the planned area—from the Medical Center to the Biomedical Research and Development Park—reflected the larger shift in vision on health care. In the 1960s and 1970s, the state agency H.E.A.L. had focused on primarily on growing the medical district through the expansion of local health institutions—the state-funded Charity Hospital and LSU Medical School and the private Tulane University Medical School, Tulane University Hospital, Hotel Dieu Hospital, Ear, Eye, Nose, and Throat Hospital, and Ochsner Hospital. In the 2000s, the city and state handed over leadership from the state agency to a private economic development organization, and placed greater emphasis on attracting outside biomedical companies. This transition represented an even greater revelation of the neoliberal
approach to the health care economy and urban governance in general. After Katrina, the state legislature passed bill authorizing the formal creation of the Greater New Orleans Bioscience Economic Development District. Similar to H.E.A.L., a Board of Commissioners would direct the district, with 12 representatives from Greater New Orleans Inc., LSU, Tulane, Ochsner Delgado Community Council, the Business Council of New Orleans, the New Orleans Chamber of Commerce, the Department of Louisiana Economic Development. This body also possessed many of the previous powers of H.E.A.L.: they could sell bonds, ask voters for an increase in property taxes, purchase land without paying property tax, and take land through eminent domain for other agencies.

With the passage of the legislation for the medical and bioscience district, proponents turned to creating the new University hospital and discussions over redesigning the larger statewide Charity system. In 2005, the Louisiana Department of Health and Hospitals organized a meeting of 100 public and private health care stakeholders that led to the formation of the Greater New Orleans Health Planning Group. Members included representatives from Louisiana Blue Cross Blue Shield; the Louisiana Department of Health and Hospitals; the Louisiana Public Health Institute; Louisiana State University; Tulane University's Medical School and School of Public Health; the New Orleans Health Department; and the U.S. Public Health Service. Thus, many of the organizations like LSU and Tulane that had advocated for replacing Charity Hospital in New Orleans for decades now would decide the fate of that hospital and the other

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hospitals in the Charity system. With input from the Rand Corporation, they produced the "Framework for a Healthier Greater New Orleans." The framework made several recommendations. First, the plan advocated addressing many of the negative social determinants of health that accounted for persisting racial health disparities. The framework called for a "health neighborhood design" that including rebuilding neighborhoods with sidewalks, recreation spaces, access to health foods, and "conditions that promote safety." Second, to directly address environmental health factors that caused health problems, the framework advocated reduction of exposure to hazardous sources, safe drinking water, reduced pollution, and improved sewage and waste management. Third, the framework recommended improving access to primary health care to lessen the need for reliance on acute care at hospitals. To achieve this goal, the plan called for several changes to the health care structure that had plagued New Orleans in the pre-Katrina period, including improved services offered by the New Orleans Health Department, expanded health education, neighborhood-based and comprehensive primary clinics affordable to all residents, and integrated health care with better collaboration and coordination between various health care institutions and professionals. Finally, the framework addressed the hospital system. The group called for "access to quality hospital and specialty care regardless of their income or health insurance." They noted that the Medical Center of New Orleans—Charity and the University Hospital—had "responsibilities for care of low-income and uninsured persons" but that "it may not have to remain the domain of a public/state facility."\textsuperscript{591} Although not explicitly stating their endorsement for LSU's long-hoped university hospital, the framework tacitly endorsed

\textsuperscript{591} "Framework for a Healthier Greater New Orleans" Executive Summary, Nov. 10, 2005.
the end of the public Charity Hospital in New Orleans and the transition to a private hospital. This was not surprising, considering representatives of LSU and their allies served on the planning group. However, if all the elements had been addressed—including reducing negative social determinants of health, providing preventative and primary care for all residents, and ensuring that all residents could use the private hospitals—then the post-Katrina period could have witnessed the end of the two-tiered health care system and a significant decrease in racial health disparities.

Ultimately, though, the policy makers focused almost exclusively on replacing Charity with LSU's university hospital as the main solution, eschewing the work to address social determinants of health or improve health care access for low-income residents. Many of the same representatives from the Greater New Orleans Health Planning Group—including those like LSU and Tulane with direct interests in replacing Charity—joined Governor Kathleen Blanco's task force on health care, which more explicitly endorsed the opening of a new university hospital. This group worked with Price Waterhouse Coopers to create a report on redesigning low-income health care service in the state. Leaked in spring 2006, the report stated that New Orleans had too many acute care beds prior to Katrina, and it questioned the need to reopen Charity Hospital. After public blowback, the final report supported the building of an academic medical center under LSU's administration to replace Charity Hospital in New Orleans, with the university giving up control of the other hospitals in the statewide Charity hospital system. The Louisiana Recovery Authority endorsed this plan in June 2006.592

After the publishing of this report, U.S. Health and Human Services Secretary

592 Clark, "Rebuilding the Past," 755.
asked the state to form a task force to redesign the state's charity hospital system in hopes of eliminating two-tiered health care. In response, Governor Blanco formed the Louisiana Health Care Redesign Collaborative, which started meeting in July 2006. In addition to many of the same members as the earlier groups, the taskforce included Louisiana state legislators, health care industry representatives, the governor's staff, and representatives from Ochsner. Governor Blanco instructed the group to include a new LSU university hospital and VA hospital as part of their final plan. The group proposed creating a state-subsidized program called the Health Insurance Connector. Enrollees could have income up to 300% of the federal poverty level (higher than the 200% threshold LSU had set before Katrina for Charity) and could use the subsidy to participate in an employer-sponsored plan, buy their own insurance as an individual, or to buy into the state's Medicaid program. Patients would have a "home" hospital or clinic that would provide their primary care. This "home" institution would also coordinate referrals with each participating hospital using the same record-keeping system to maximize efficiency and reduce duplication of services. As such, the plan represented an attempt at "integrated health care" for the uninsured, similar to the setup of hospital systems like Ochsner. Secretary Leavitt told members of the Louisiana Health Care Redesign Collaborative repeatedly that he wanted to eliminate the two-tiered health care system that existed prior to Katrina, with the indigent and low-income using Charity Hospital, and middle and upper income using the private hospitals. The federal government countered the state's plan in January 2007 with a proposed statewide insurance program for half of uninsured Louisianans, with funding from the DSH, and Medicaid covering other residents through a managed care programs.
While officials debated the various proposals, LSU moved forward with their own plan to create a new university hospital, finding a partner with the VA Hospital. Prior to the storm, the VA Hospital existed adjacent to Charity on Perdido Street in the Medical District. Like Charity, the VA Hospital received flood damage, and the federal government decided not to reopen the hospital, originally built in 1951. Ochsner lobbied the government to move the hospital adjacent to their main campus in Jefferson, and other politicians pushed for moving the hospital to other locations in Louisiana or outside of the state. In 2006, the municipal government released the Unified New Orleans Plan, mandated by FEMA and HUD for the city to receive federal funding. That plan, approved by those agencies, detailed neighborhood recovery proposals, including building the VA and Charity hospitals on a shared 37-acre area half a mile from Charity's location on Tulane Avenue. Residences occupied that site, also on Tulane Avenue but across the street and bounded by Canal, N. Galvez, and N. Prieur Streets. LSU quickly signed a memorandum of agreement with the Veterans Administration to create a shared building that would contain housekeeping, the cafeteria, and an energy plant, believing this would help strengthen their position in pushing for their own hospital. However, the Nagin administration then threatened to deny $75 million dollars in HUD funding for the VA Hospital unless it agreed to move to another 30-acre site, separate from Charity Hospital, across Galvez Street and further into the residential area of the Tulane Gravier neighborhood. LSU would be able to keep the original 37-acre site solely for their hospital, and thus the proposed 37 acres became 67 acres. In 2008, the Department of Veterans Affairs signed a memorandum with the city to build the VA hospital. To build the VA hospital—originally projected to cost $625 million dollars, but ultimately totaling
$1.2 billion dollars—the city planned to use their municipal eminent domain power to seize property and raze homes and businesses on the site. As in the case of H.E.A.L.'s plan to displace Black residents and businesses in 1971, residents organized against this effort, and sued the city in 2009 for signing the memorandum of agreement with the VA hospital without required public hearings or approval by the City Council and in violation of the City Charter. In response, in 2010 the City Planning Commission and the City Council exempted the relocation of the VA hospital to the 30-acre site from the city's Master Plan. This allowed the municipal government to approve the proposal without going through public meetings or receiving any form of public input—including the opportunity for residents to voice opposition or suggest alternate sites—which was mandated under the Master Plan.

With the full backing of the city and state leaders, LSU turned towards securing their own new hospital. The administrators of LSU remained determined to use DSH funding—which covered 67% of Charity Hospital's costs prior to Katrina—to support their new hospital even as the federal government proposed ending that allocation and instead using that funding for the statewide insurance program for the uninsured. State leaders ultimately rejected the federal government's plan; as noted by political scientist Mary A. Clark, those who benefitted from maintaining the current system—state leaders who wished to continue to control and redistribute federal DSH funding—resisted the federal efforts, as did LSU and their allies who wanted to use DSH funding at their new university hospital. In April 2007, LSU announced a proposed $1.2 billion dollar, 484-

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593 Thurman et. al v. Nagin, Civil District Court for the Parish of Orleans 09-7244 (2009).
bed hospital (up from the $650 million, 350-bed proposal in 2004). To afford the hospital, LSU needed disaster funding from FEMA, $300 million dollars that HUD had already designated for the Louisiana Recovery Authority, as well as state allocations and bonds. LSU, Tulane, and their political allies successfully pressured the state legislature and HUD to approve the reallocation of the agency's funding.\(^595\) Next, they had to secure FEMA's funding. In late 2005, FEMA estimated that Katrina caused $23.9 million dollars in damages to Charity, less than one tenth of LSU's estimate of $257.7 million dollars in damages. LSU's administrators pushed for the higher amount to support their claim that Charity should not be repaired but rather had to be replaced, as federal regulations stipulated that if costs exceeded 51% of the value of the building, it would need to be replaced. Charity hospital staff and military officers later accused LSU of hiring individuals who purposely trashed the hospital to convince federal officials that the hospital was unfit for reopening.\(^596\) Governor Blanco backed LSU's call for a new hospital, over the objections of the New Orleans City Council and local activists. In 2008, after a joint study between FEMA and the state, the former raised their estimates to $150 million dollars, while LSU upped their estimate to $492 million dollars. FEMA concluded that the damages did not exceed the 51% threshold, and that LSU and the state were attempting to use federal funding to pay for repairs and upgrades long deferred before the storm. LSU appealed FEMA's estimate of $150 million dollars in March 2009. With lobbying from Senator Mary Landrieu and Congressman Anh Cao, the state successfully won an arbitration appeal in 2010, securing their 2008 call for $475 million dollars from FEMA. Forty years after LSU helped push through H.E.A.L. legislation with a desired goal of building a new

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\(^{595}\) Clark, "Rebuilding the Past," 755.

\(^{596}\) Gratz, "Why Was New Orleans's Charity Hospital Allowed to Die."
university hospital as part of an expanded medical district, they finally secured funding to accomplish their goal.597

In 2011, contractors broke ground on the University Medical Center hospitals. In 2012, LSU transferred management of the still under-construction University Medical Center and the University Hospital to LCMC Health, the hospital company that also managed Children's Hospital and Touro. With LCMC's takeover, the University Hospital became a private hospital. While the construction of LSU's new University Medical Center continued, the University Hospital—the former Hotel Dieu—maintained its role as the city's public hospital and only level 1 trauma center, despite only having 235 beds in operation by 2014. On August 1, 2015, nearly a decade since LSU closed Charity Hospital, the new University Medical Center opened. With the hospital's opening, LCMC closed the University Hospital. In November 2016, the VA Hospital—formally the Southeast Louisiana Veterans Health Care System Veterans Medical Center—opened its 1.7 million square foot institution. The opening of the University Medical Center and the new Veterans Administration Hospital marked the formal advent of the BioDistrict New Orleans (formerly the Greater New Orleans Biosciences Economic Development District). The 1,500-acre district included the two hospitals, and extended to Carrollton Avenue, Earhart Boulevard, Iberville Street, and Loyola Avenue, occupying a large swath of upper Mid City, the Medical District, and Gert Town. In addition to hospitals, the medical schools, and bioscience companies, planners stated that the district would also have a projected 29,000 square feet of retail space and amenities like green space and bike lanes to attract workers. Leaders estimated that the BioDistrict would produce

597 Ott, "The Closing of New Orleans's Charity Hospital," 91-104.
$9.6 billion dollars in earnings in its first twenty years and create more than 17,000 jobs. By the 2010s, New Orleans increasingly relied upon the health care sector as a key driver of the local economy. In fact, a 2017 report found that New Orleans had the largest health care sector job growth of any city in the U.S. in the previous decade.\footnote{Andrew Joseph, "STAT List: These 10 cities had the biggest jumps in hospital jobs," \textit{STAT News}, Oct. 11, 2017.}

Yet, as developers, politicians, and hospital leaders celebrated their success in finally replacing Charity and fulfilling H.E.A.L.'s 50-year quest to establish a biomedical district, others decried the process and the negative impact on low-income residents. In a repeat of the WPA-sponsored "slum clearance" of Black residences and businesses in the Tulane Gravier neighborhood in the 1930s to build the last Charity Hospital, the city and state used their eminent domain power—again, supported by federal funding—to raze 265 homes and dozens of businesses in the predominantly Black Lower Mid City neighborhood for the UMCNO complex in the 2010s. They did so even after a 2009 state legislature-sponsored study by the Foundation for Historical Louisiana and the RMJM Hillier architectural firm found that the Charity Hospital structure was still sound and could be renovated and reopened within three years for $550 million dollars—less than half the $1.2 billion dollars for the UMCNO—without displacing any residents.\footnote{RMJ M Hillier, "Medical Center of New Orleans Charity Hospital: Feasibility Study," (2008).}

Additionally, local officials and residents never voted on LSU’s plan for the Medical Center, and the planners incorporated no feedback from residents at the handful of public meetings. As stated by Sister Vera Butler of St. Joseph's Church on Tulane Avenue: “a few neighborhood meetings were held in 2008 and 2009, and conversations were going on but it was difficult to get any concrete information. There was never a
point person you could go to. You couldn’t find out who to ask, who to call.” Instead, the designers used the plans previously developed prior to Katrina, and then expanded in 2007.\textsuperscript{600} The displacement of the 265 families and dozens of businesses drastically altered the makeup of the Lower Mid-City neighborhood, which was predominantly Black and low-income, and had disproportionate numbers of elderly residents and workers in the service sector. Some of the displaced residents had only recently moved back into their homes after rebuilding, including using Road Home funding, a short-lived federal program that aimed to help Louisianans repair or rebuild homes damaged or destroyed during Katrina.

Many of the families had resided in the neighborhood for generations. As told by Sister Butler: “You had people living here whose grandparents had grown up here,” she said. “But they’ve now gone to Gentilly, Jefferson Parish and out of state. It’s a scattered, broken community now.”\textsuperscript{601} Many displaced residents faced difficulty in finding new homes. The area had some of the lowest property values and rents in the city. When forced out through eminent domain, the city and state gave homeowners the market value of the property prior to the start of development. In the wake of the storm, housing prices had increased and affordable housing had decreased, and many residents could not find new homes. In addition to directly displacing those individuals, the building of the two hospitals and the creation of the BioDistrict started a significant process of gentrification in the neighborhood and the surrounding areas. The planners of the hospitals and the districts not only created spaces for the hospitals and other biomedical sites, but they also

\textsuperscript{600} Gratz, "Why Was New Orleans's Charity Hospital Allowed to Die."
closed streets, created green spaces, and developed new housing units to attract doctors, medical students, and biomedical workers. The resulting increase in property taxes and rents forced many other residents to leave the increasingly unaffordable area. Using data that included income, proportion of housing built in the past 30 years, education levels, and housing prices, scholars Eric Joseph van Holm and Christopher Wyczalkowski identified the neighborhood as one of areas that had the highest level of gentrification in the decade after Katrina.602

Beyond the displaced residents, the shift from Charity to the UMCNO affected tens of thousands of other low-income, predominantly Black residents through the change in the hospital's mission. As stated by LSU Health Sciences Center Chancellor Dr. Larry Hollier in 2006, administrators were "absolutely committed to keeping us away from the charity model" and instead were interested in following the "academic center model." In fact, LSU focused on rebranding the hospital by dropping the "Charity" name, in an attempt to remove the "stigma" and become known as a "destination" hospital where patients from throughout the region, the country, and internationally would come for specialized care. The mission and vision statements of the UMC reflected this shift with the former stipulating that "UMCNO will provide exceptional patient-centered care and a world-class academic experience through advanced research, leading technology and innovation" and the latter holding that the hospital would be the "destination choice for exceptional health care."603 As required by their state contract, the UMCNO patient mix

had to include at least 20% uninsured individuals. However, this marked a drastic change from their pre-Katrina mission to only provide care for uninsured or individuals under 138% of the federal poverty level. LSU had been pushing to allow paying customers to use Charity Hospital prior to the storm without success. In the wake of the disaster, they finally succeeded in changing the allowable patient mix. This change occurred on top of the sharp reduction in beds, from over 1,300 beds between Charity and the University Hospital to 446 beds by 2018 at the UMCNO. With a 60% reduction in in-patient beds, and a turn towards attracting paying patients and serving as a "destination hospital," the UMCNO now serves only a fraction its traditional patient population, predominantly low-income Black New Orleanians.

Pendleton Memorial Methodist Hospital underwent a similar transformation. The 181-bed hospital, which had become the city's second largest Black patient-serving hospital in the two decades leading up the storm, closed during Katrina and did not reopen, leaving the predominantly Black New Orleans East without a hospital for nearly a decade after the storm. In 2014, LCMC Health—which operated the UMCNO and West Jefferson Medical Center—opened the New Orleans East Hospital on the site of the former Pendleton Memorial Hospital. The 80-bed hospital—a reduction in beds of 56% from the pre-Katrina hospital—served an area with 80,000 residents.604

**Primary Clinics and Federal Funding**

One positive change for low-income residents post-Katrina was the expansion of primary care clinics. After the storm, the St. Thomas Community Health Center expanded its services with a $500,000 disaster grant. By the end of 2005, the clinic saw

120 patients a day and provided services on a sliding scale, with free care for indigent residents and those affected by homelessness. The clinic moved to a new location on Magazine Street, renovated in 2012 with an $850,000 Community Development Grant from the city. By 2015, 45,000 patients a year visited St. Thomas's clinics. In 2017, St. Thomas opened the Heart and Vascular Center on Magazine Street, another clinic on St. Bernard Avenue. Other community-based clinics grew or started in post-Katrina New Orleans. In addition to the previously detailed Common Ground clinic, the New Orleans Musicians' Clinic expanded, supported by the New Orleans Musicians’ Assistance Foundation, a 501(c) non-profit started in 2005. They later moved to the LSU Health Faculty Practice Clinical building on St. Charles Ave.

Federal funding helped fuel the growth of primary care clinics. In 2007, Congress appropriated $100 million dollars in the form of a "primary care stabilization grant" to help low-income residents who surpassed the state's income threshold—the second lowest in the nation—for Medicaid get primary care. Local proponents created the Greater New Orleans Community Health Connection in 2010 to coordinate efforts to lobby the federal government for additional funding and create a shared pool for grant money. Through a mix of local, state, and federal funding—primarily Medicaid funding—the GNOCHC distributed money to low-income residents to cover primary care, but not hospitalization or medications. By 2014, over 53,000 residents had enrolled

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606 "History of the New Orleans Musicians Clinic," https://neworleansmusiciansclinic.org/about/about-nomc/history-of-the-nomc/
in the GNOCHC program, which covered 97,000 clinic visits that year.\footnote{Jeff Adelson, "Programs that Provide Health Care to Thousands of Verge of Going Broke," \textit{Times Picayune}, April 29, 2014.}

The funding not only helped residents, but also supported the primary care clinics like St. Thomas and Common Ground. Both became federally qualified health centers (FHQC). The FQHC program provided funding to eligible community-based health care organizations that provided primary care services in underserved areas in the form of grant money and Medicaid reimbursement. By 2016, New Orleans had twelve organizations with the FQHC status with 40 clinic locations.\footnote{New Orleans Health Department, "Community Health Improvement plan, 2\textsuperscript{nd} Revision" (2016).} Additionally, the Affordable Care Act provided more funding for community-based health centers. In 2017, including the 40 FHQC clinics, over 70 community health centers provided services for over 59,000 residents.\footnote{Urban League, "State of Black New Orleans," 129.}

State funding continued to undermine efforts to further help low-income residents. The state used federal Community Development Block Grant funding to cover their share of the costs of the GNOCHC program. However, as enrollment grew and required additional state funding, Governor Bobby Jindal's administration refused to support more state spending, leading to the near ending of the GNOCHC in 2014. The passage of the Affordable Care Act offered health insurance for many previously uninsured residents, leading to significant reductions in the uninsured rate, although Black residents still had an uninsured rate of 16% in 2014, down from 32.3% in 2009-2011, compared to the white rate of 11% in 2014, down from 16.6% in 2009-2011.\footnote{Urban League, "State of Black New Orleans," 27.}

Under the Affordable Care Act, in 2014 the federal government offered additional
funding to expand Medicaid to individuals that made up to 138% of the federal poverty level, but the Jindal administration refused to accept the money.\textsuperscript{611} As a result, thousands of low-income residents that slightly exceeded the federal poverty level—ranging from an individual making $11,670 to a household of four with an income of $23,850—were not eligible for federally-subsidized health care and thus largely unable to access health care. Under the administration of new Governor John Bel Edwards, Louisiana finally accepted federal Medicaid expansion to include residents that made up to 138% of the federal poverty level. Going into effect in July 2016, this change automatically enrolled the GNOCHC participants—over 63,000 by that point—in Medicaid. This expansion shrunk the uninsured rate in New Orleans 11.5% in 2017. Overall in New Orleans in 2017, Medicare provided health insurance for 6.5% of residents, and Medicaid for 23.3% of residents, with 51.2% of residents covered by employers.\textsuperscript{612} The rise of the FQHC clinics led to a significant change for the New Orleans Health Department. Starting in 2010, the NOHD shifted from its previous role as the primary providers of clinics for low-income residents to a more policy-focused mission. Since then, the NOHD has focused on implementing federal programs like the Healthy Start Initiative that targeted areas with high percentages of low-weight newborns.\textsuperscript{613}

\textsuperscript{611} Jeff Adelson, "Programs that Provide Health Care to Thousands of Verge of Going Broke," \textit{Times Picayune}, April 29, 2014.
\textsuperscript{613} Urban League, "State of Black New Orleans," 126. A 2010 study of 392 low-income survivors found that the rate of serious mental illness doubled, and that almost half suffered from PTSD. Additionally, they found that those that suffered the most severe losses and stresses from the storm suffered the highest rates of severe mental illness and PTSD. In New Orleans, low-income Blacks disproportionately suffered the highest flooding rates and deaths, thus exposing them to disproportionate rates of mental illness. 
Mental health services remain severely lacking, especially problematic as many survivors of Hurricane Katrina suffered from post-traumatic stress disorder and other mental health issues due to the disaster. Even prior to the storm, New Orleans lagged behind other cities in providing health care and hospitalization for individuals affected by mental health problems. Scholars posited that prior to Katrina, New Orleans lacked adequate mental health services and psychiatric beds in hospitals, with an estimated need of an additional 226 beds.\textsuperscript{614} Katrina exacerbated these problems, as the city had 39% fewer adult and 25% fewer child psychiatric beds a decade after the storm, with most beds lost at Charity Hospital.\textsuperscript{615} Even as the city faced these severe shortage from closed hospitals, the Jindal administration closed the New Orleans Adolescent Hospital and made additional cuts for psychiatric beds at DePaul Hospital and a reduction in mental health services for prisoners.\textsuperscript{616} In addition to fewer hospital beds, many psychiatrists did not return to the city. In 2005, 196 psychiatrists practiced in the city; in 2010, only 65 practiced, and only 3 of these accepted Medicaid patients.\textsuperscript{617} As happened in most areas of health care, the decline in mental health beds and services disproportionately impacted


\footnotesize{\textsuperscript{614} Urban League, "State of Black New Orleans," 128.}

\footnotesize{\textsuperscript{615} Danielle Broussard, Lisa Richardson, Maeve Wallace, and Katherine Theall, "Advancing Health Equity in New Orleans: Building on Positive Change in Health," (New Orleans: The Data Center, 2018). Charity Hospital had 128 long-term psychiatric beds and fifty crisis psychiatric beds open in 2005; by the end of 2015, University Hospital had only 44 psychiatric beds, up to 60 by 2018. New Orleans Health Department, "New Orleans Mental Health Dashboard" (New Orleans: NOHD, 2016).}

\footnotesize{\textsuperscript{616} Urban League, "State of Black New Orleans," 126.}

low-income, Black residents.\textsuperscript{618}

In addition to the radical changes to the post-Katrina health care system, many of the social determinants of health worsened for Black residents. As white, highly-educated, upper income residents moved to the city and began buying houses in formerly predominantly Black, low-income neighborhoods, New Orleans underwent increasing gentrification and residential racial concentration. In the decade after Katrina, sixty-two census tracts significantly gentrified.\textsuperscript{619} Gentrification paired with increased racial concentration as neighborhoods like the Bywater, Carrollton, the Irish Channel, the Marigny, St. Roch, Uptown, Mid City, Algiers Point, and Milan became more white, while New Orleans East and Gentilly became more Black.\textsuperscript{620} The racial makeup of the city as a whole changed; by 2015 more than 100,000 Blacks had not yet returned to the city while the white population returned to near pre-Katrina levels, shrinking the Black percentage from 67% to 59 percent, and increasing the white percentage from 27% to 31 percent.\textsuperscript{621} Many of the economic indicators for Black residents became worse in the years after Katrina. The economic gap widened between Black and white residents, as

\textsuperscript{618} Overall, a significant difference still existed in perceptions about healthcare. In a 2010 survey of residents, 51% of Africans Americans stated that their health needs were "well met," compared to 66% of whites. A racial divide existed among the uninsured and among those below 200% of the poverty level: 60 and 69% of white respondents in each group stated their health care needs were "well met" compared to 27 and 41% of Black respondents in each group. New Orleans Health Department, "Health Disparities in New Orleans" (New Orleans: NOHD, 2013), 7. In a 2015 survey of city resident, 64% of respondents stated there were not enough healthcare services for low-income and uninsured residents. In that same survey, one third of respondents with incomes below 200% of the federal poverty level and 47% of uninsured residents stated they had skipped or delayed medical care in the preceding six months due to costs. Broussard et al., "Advancing Health Equity in New Orleans."

\textsuperscript{619} Van Holm and Wyczalkowski, "Gentrification in the Wake of a Hurricane."


\textsuperscript{621} The Latinx population grew from 3% to 5 percent. Ibid.
Black income and unemployment worsened while both numbers improved for whites.\textsuperscript{622} Black New Orleanians became increasingly concentrated in low-paying employment sectors, primarily hospitality and service jobs, as rent and housing prices increased with gentrification and the city's demolition of public housing units.\textsuperscript{623} Black New Orleanians had poverty rates six times higher than whites, with poverty concentrated in predominantly Black neighborhoods like Central City, Desire, and the Seventh Ward.\textsuperscript{624} Beyond poverty, Black residents disproportionately faced many other problems that negatively affected health including poor quality housing, low levels of education, lack of access to grocery stores, high rates of crime victimhood and incarceration, and continued exposure to environmental hazards.\textsuperscript{625}

The continuance of these negative social determinants of health led to the persistence in the racial health gap in the post-Katrina period. In 2013, Black New Orleanians suffered from hypertension or high blood pressure at a rate 65\% higher,\

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\textsuperscript{622} In 2015, Blacks in 2015 had an unemployment rate of 15.3\% compared to a white rate of 5.1\% percent. Corporation for Enterprise Development, "The Racial Wealth Divide in New Orleans." In 2016, the median Black household income was $25,324 dollars, compared to $35,683 for Latinx and $67,884 dollars for whites. Allison Plyer and Lamar Gardere, "The New Orleans Prosperity Index" (New Orleans: The Data Center, 2018).

\textsuperscript{623} Over 71\% of Black households earned less than what MIT projected to be a living wage of $47,200 dollars in New Orleans in 2016, compared to 56\% of Latino and 31\% of white households. The destruction of the city's large public housing complexes led to an 84\% reduction in public housing units. Jane Henrici, Chandra Childers, and Elyse Shaw, "Get to the Bricks: The Experience of Black Women from Public Housing after Hurricane Katrina," (Washington, D.C.: Institute for Women's Policy Research, 2015), viii.

\textsuperscript{624} Other neighborhoods were B.W. Cooper, the Bywater, Central Business District, East Riverside, Fischer, Florida, Gert Town, Iberville, Irish Channel, Lower Ninth Ward. CFED, "The Racial Wealth Divide in New Orleans."

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asthma at a rate of 70% higher, and diabetes at a rate 40% higher. By 2016, Black New Orleanians were six times more likely than whites to contract HIV/AIDs, and twice as likely to die. This mortality gap existed for other diseases as well: Blacks were 1.33 times as likely to die from heart disease; 1.55 times as likely to die from cancer; 2.32 times as likely to die from kidney disease; 3 times as likely die as an infant; 3 times as likely to die from diabetes; and 1.07 times as likely to die from all other diseases.

Overall, Blacks were 1.37 times more likely to die at any age than white New Orleanians. The New Orleans Health Department calculated for the period from 2008-2010 that Blacks had an overall avertable death rate of 30 percent, meaning that if they had the same death rate as whites, 30% of Black deaths would not have occurred.

The culmination of these health factors led to significantly lower life expectancies for Black New Orleanians, particularly those in the neighborhoods with the highest concentrations of Black residents and poverty rates. Using numbers from 2010-2015, the U.S. Small-area Life Expectancy Project—conducted by the CDC's National Center for Health Statistics, the Robert Wood Johnson Foundation, and the National Association for Public Health Statistics and Information Systems—found that the residents of the Hoffman Triangle neighborhood (adjacent to Central City), a predominantly Black low-

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626 Blacks also suffered from a low birth rate double that of whites; premature birth at nearly double that of whites Broussard et al., "Advancing Health Equity in New Orleans," 8.

627 May 6, 2019. Blacks continued to suffer from significantly higher rates of HIV/AIDs. From 2004 onward, New Orleans ranked in the top ten cities in per capita cases, and would continue to do so for the following decade, ranking 2nd for HIV cases and 5th for AIDs cases in 2014. Kimberly Curth," New Orleans Facing HIV Epidemic," Fox 8 November 18, 2016. National Center for HIV/AIDs, "Louisiana Department of Health and Hospitals" (Atlanta: CDC, 2015).

628 Broussard et al., "Advancing Health Equity in New Orleans."

income neighborhood, had the lowest life expectancy of 62.3 years of age and Lakeview again had the highest at 88.1 years of age. All the neighborhoods with high life expectancy were predominantly white and had low levels of poverty.

**Summary**

The continuation of the racial health and mortality gap attests to the perpetuation of a two-tiered health care system, one with deep historical roots tied to the larger system of white supremacy. From the founding of New Orleans, two health care systems existed: one for whites, and another for Blacks. In the earliest system, Blacks suffered from exclusion and exploitation. Enslavers based their decisions to seek medical care for enslaved people based upon a cost-benefit analysis: the potential loss of investment—money spent to purchase the enslaved person as well as the loss of value of their future labor—versus the cost of medical treatment and the likelihood of success. Doctors too viewed enslaved individuals through a similar financial lens: income from treating enslaved people, including starting a private hospital with a wing for enslaved patients; professional advancement from pioneering medical procedures or gaining proficiency in a medical procedure they did not already possess by experimenting on enslaved patients; and standing from running a medical school that utilized Black bodies in hospitals as teaching cases and Black corpses for anatomical lesson. For enslavers and physicians

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630 The areas with next lowest average life expectancy: the Upper Ninth at 62.6 years; the Seventh Ward at 64.8; St. Roch at 65.3 years; Desire at 66 years; Treme at 66.4; Holy Cross at 66.6; and B.W. Cooper at 67.5. The areas with next highest life expectancy behind Lake View were: West End at 82.7 years; Carrollton at 82.8 years; Freret at 83.7; and Lakeshore-Lake Vista at 85.1 years of age. Additionally, several suburbs of New Orleans ranked in the top ten of life expectancy for the greater metropolitan area: Mandeville at 83 years; Old Metairie at 83 years; and Madisonville at 83.6 years. Louisiana Budget Project, "Location and Life Expectancy in New Orleans" (Baton Rouge: LBP, 2018). E. Arias, L.A. Escobedo, J Kennedy, C. Fu, and K. Cisewski "U.S. Small-Area Life Expectancy Estimate Project" (Atlanta: CDC, 2018).
alike, slavery proved profitable, and physicians and hospitals played a key role in
upholding the slave system, with pseudo-scientific arguments used to justify slavery, and
doctors treating enslaved people to prevent the spread of disease, increase the prices of
slave traders, back redhibition policies, and return enslaved people to labor. In return,
money from treating enslaved people—paid by slave traders and enslavers—sustained the
burgeoning health care system in New Orleans, allowing it to prosper by the Civil War.

The Civil War disrupted these two systems, slavery and the health care sector.
The conflict and federal occupation presented a potential turning point for Black health
care. The creation of the Freedman's Hospital and the end of racial discrimination at
Charity Hospital opened access to health care for Blacks, residents and refugees, for a
brief period. However, the promise of this crucial turning point quickly vanished. The
end of Reconstruction—which included the closing of the Freedman's Hospital, the return
to power of the Democrats; and the decisions by the leaders of the health care system to
maintain apartheid health care—ended this brief point of more equal access, and led to
the institutionalization of Jim Crow, including in health care. The newly formed Orleans
Parish Medical Society instituted a whites-only member clause, all private hospitals
refused to admit Black patients, and Charity Hospital re-segregated. In the post-Civil War
period, the racial health gap widened dramatically. Black life expectancy fell below white
life expectancy as the Black mortality rate doubled that of whites.

In the early twentieth century, New Orleans initiated public health campaigns and
municipal improvements to support newly emerging economic systems: trade with Latin
America and tourism. However, these efforts primarily benefited white residents, and
excluded Blacks. Akin to earlier periods, pseudo-scientific ideas helped support the larger
system of Jim Crow, as whites used supposed public health concerns to justify segregation. Thus, in the late nineteenth and twentieth centuries, public health and Jim Crow became part of a self-reinforcing cycle. Segregation and other elements of Jim Crow and white supremacy created negative social determinants of health: lack of access to health care; unemployment, economic inequality, and low income; overcrowded and low-quality housing; neighborhoods without water, sewage, or drainage; exposure to health hazards, including flooding and pollutants, in Black neighborhoods; underfunded and decaying schools; violence at the hands of police officers and white residents; everyday stress from discrimination; and other factors, all products of white supremacy, that led to higher rates of disease and mortality. Instead of addressing the underlying issues, white officials used the racial health disparities to support their notions of Black inferiority and the need to segregate and spatially contain Black residents.

Excluded from the white health care system and facing these negative social determinants of health, Black New Orleanians fought for improved health. Building on the earlier efforts of enslaved and free individuals to provide care for themselves, Blacks in the late nineteenth and twentieth century became doctors and lay healers; started medical colleges—the two failed attempts at Straight University and New Orleans University, and later Flint Medical College; built Flint Goodridge Hospital; created an alternate Black medical district in Central City; and carried out public health campaigns. They did so even as white leaders forced the closure of Flint Medical College, removed Black medical institutions from the growing medical district in Tulane Gravier, used municipal powers to restrict the expansion of Flint Goodridge Hospital, and refused to desegregate the health care system.
With pressure from federal court rulings and legislation like the Civil Rights Act of 1964, Black New Orleanians finally succeeded in ending legally sanctioned segregation in health care in the late 1960s, marking another potential turning point for Black health and health care. By the late 1960s, Black health care and health activism reduced the Black mortality gap from more than double that of whites as late as 1930 to only 10% higher. Court-ordered integration and growth of NOHD and Model City primary care clinics should have led to the further closure of the racial health gap and equal access to health care.

Yet, apartheid health care and racial health disparities not only persisted, but intensified in the following decades as formerly all-white hospitals continued to deny admission to Black patients or hire Black doctors, private hospitals dumped Medicare and Medicaid patients on Charity and Flint Goodridge, and funding for Charity, the NOHD clinics, and the Model City clinics evaporated. Like other cities, New Orleans experienced a boom in the health care economy in the latter decades of the century, and the health care sector became an increasingly important component of the economy. Buoyed by taxpayer bonds and government funding, white flight hospitals helped support white suburban growth. While hospitals like Ochsner—which received federal Hill-Burton and state H.E.A.L. funding—and Tulane—also a recipient of H.E.A.L. aid—prospered, Flint—denied additional Hill-Burton funding and H.E.A.L. aid—and Charity struggled financially, with the former closing in 1985 and the latter serving as the de facto Black and low-income hospital. Negative social determinants of health also worsened in the decades after integration, with growing economic inequality.

The post-Katrina health care system changed drastically. In a controversial move,
LSU refused to reopen Charity Hospital, and instead used political lobbying to secure funding to build their long-desired University Medical Center, opened in 2015 with a new mission that purposely abandoned the charity model. Primary care clinics grew, helped by federal funding, and the eventual expansion of Medicare too increased health care for low-income residents. Yet, the racial health gap and two-tiered health care remains. As this work has demonstrated, the persistence of this inequality was not inevitable. Crucial turning periods after the Civil War, the Civil Rights period, and post-Katrina could have led to the end of apartheid health care. Instead, purposeful decisions by health care and municipal leaders, with support from state and federal officials and funding, prevented the abolishment of this system, despite efforts by Black health activists.

**Recommendations**

Although two-tiered health care and racial health disparities are deeply entrenched and need radical changes—including a shift away from a for-profit health care system and the dismantling of structural racism—for eradication, studying the history of these inequalities allows us to see steps that can and must be taken to make improvements. As the UMCNO becomes one of the centerpieces of the health care system in New Orleans, and as the city increasingly focuses on the health care economy as a financial boon, several matters should be considered. First, significant changes must occur in health care. The health care field in New Orleans has deep historical ties to supporting a racist hierarchy and segregation. Health care professionals need to incorporate this history into their training—for example, classes on the subject in medical schools like Tulane and LSU—as well as instruction on equity. Fortunately, the People's Institute for Survival and Beyond, based out of New Orleans, offers training on equity, which it has provided for
the staff of the New Orleans Health Department and several other health clinics and centers. Other health care institutions should utilize these workshops. As argued by the scholars who wrote the report "Advancing Health Equity in New Orleans:"

Having public health and health care practitioners bring about systems-level changes to promote health for all New Orleans residents requires acknowledging that existing systems were built from racist frameworks as well as acknowledging the need for larger changes in social norms to appropriately and sufficiently address equity.631

The classes and equity workshops should address the historical reasons that Black residents do not trust health care institutions, including hundreds of years of neglect, exploitation, and experimentation. This history has led to significantly lower levels of trust in health care and subsequently lower levels of use. Beyond education, the health care field needs to address problems of racial sorting and underrepresentation of Blacks in positions like physicians and surgeons. This needs to start with medical schools, which need to improve the dismal number of Black students. Blacks make up over 32% of the Louisiana's population but only 4% of medical students.632 Preliminary research has found that increasing the number of Black doctors can have significant positive impacts on improving use of preventative services and a corresponding decrease in mortality.633 Additionally, the continued racial sorting and segregation in the health care field has larger negative effects that extend beyond patients. As noted by Rhea Boyd in the June 2019 edition of the Lancet:

In places where health-care institutions are the largest local employer, failure to fully desegregate the workforce and leadership can exacerbate local racial income or wealth gaps; re-enforce gentrification and residential segregation in

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631 Broussard et al., "Advancing Health Equity in New Orleans.," 10.
632 Broussard et al., "Advancing Health Equity in New Orleans.," 10.
neighbourhoods near medical centres; and compound local racial health inequities.\textsuperscript{634}

The threats of these impacts will only worsen as New Orleans increasingly focuses on promoting the health care economy, primarily through the form of the BioScience District. The health care field is already one of the largest employment sectors in the city, ranking only behind hospitality and tourism, with tens of thousands of workers. The leaders of the BioScience District and other health care employers must address the perpetuation of segregation in health care to prevent further damage. The leaders of the BioScience District and other health care institutions must also address the gentrification it is causing in the city. While potentially luring in highly educated workers, the BioDistrict threatens to displace more low-income residents through expansion and by raising property taxes and rents. Beyond physically removing those residents further from the main institution for low-income hospital care, studies have found that gentrification and displacement can cause significant physical and mental health problems.

Occurring increasingly throughout the city, gentrification is just one of many of the negative social determinants of health that health and other city leaders must address. Inequality in access to education; lack of safe and affordable housing and neighborhoods; economic instability and wealth inequality; lack of access to recreation spaces; exposure to health hazards; gentrification; racism; and other factors have exacerbated the inequality in access to health care and perpetuated the racial health gap as seen in the significantly higher rates of disease and mortality for Black residents versus white New Orleanians. While fixing systemic and institutional racism is a monumental task, leaders

\begin{footnote}{\textsuperscript{634}} Rhea Body, "The Case for Desegregation," \textit{The Lancet} 393, no. 10190 (June 2019): 2484.\end{footnote}
must recognize that failing to do so is literally killing Black residents and lowering their life expectancy. This work has identified the crucial turning points in the history of the apartheid health care system, moments where leaders could have dismantled that system. It is my hope that by studying this history, and analyzing these lost points of potential change, the leaders of New Orleans today—both inside and outside of the health care system—can make the changes necessary to finally end the city's apartheid health care system.
APPENDIX A: ARCHIVES AND COLLECTIONS USED

Amistad Research Center (ARC)
   Albert and Jessie Dent Family Papers
   American Missionary Association Collection
   A.P. Tureaud Papers
   Daniel Ellis Byrd Papers
   Economic Opportunity Corporation Records
   Ernest "Dutch" E. Morial Papers
   Dunn-Landry Family Papers
   George Thomas, Jr. Papers
   Henry E. Braden III Papers
   Joseph Hardin Papers
   Kim Lacy Rogers Collection
   Marc H. Morial Papers
   National Association for the Advancement of Colored People, Office of Field Director of Louisiana Records (NAACP)
   New Orleans Sickle Cell Anemia Foundation Collection
   Rivers Frederick Papers
   Robert Elijah Jones Papers
   Rosa Freeman Keller Papers
   Small Collection
   Tom Dent Papers

City Archives, New Orleans Public Library (CANOPL)
   Charles Franck Collection
   City Planning and Zoning Commission Records
   Commission Council Series
Correctional Institution Records
Councilman Sidney J. Barthelemy Subject Files
DeLesseps S. Morrison Collection
Eye, Ear, Nose & Throat Hospital Records
Flint Goodrich Subject File
Friends of the Cabildo Oral History Project Collection
H.E.A.L. Collection
Hospitals Collection
Hospital & Insanity Records
Housing Authority of New Orleans Collection
Mayor Andrew McShane Papers
Mayor Arthur J. O'Keefe Records
Mayor Chep Morrison Records
Mayor Ernest N. Morial Records
Mayor Marc H. Morial Papers
Mayor Martin Behrman Records
Mayor Robert S. Maestri Records
Mayor Sidney J. Barthelemeay Records
Mayor Victor Hugo Schiro Collection
New Orleans Health Department Collection (NOHD)
New Orleans Planning Records
Records of the City Councils
Rosa Keller Papers
Sanborn Fire Insurance Maps
Woods Directory
WPA Photograph Collection
Delgado Community College Library
Louisiana Collection
Dillard University Archives (FGHCDU)
Flint Goodridge Hospital Collection
Ethel and Herman Midlo Center for New Orleans Studies, University of New Orleans
Oral History Project Collection
Historic New Orleans Collection
Franck-Bertacci Photographers Collection
Howard University Archives
Peter Marshall Murray Papers
Joel Buchanan Archive of Black History, University of Florida
African American History Project Oral Histories
Louisiana Collection, University of New Orleans (LCUNO)
A.P. Tureaud Collection
Charity Hospital School of Nursing Collection
Community Services Council of New Orleans, Inc. Collection
Department of Health & Hospitals Vertical Files
Edgar Hull Papers
Marcus Christian Collection
National Association for the Advancement of Colored People, New Orleans Branch Collection (NAACP)
New Orleans Community-Oral History Collection
Patricia Williams Collection
Sidney J. Barthelemy Collection
Library of Congress
Archives du Ministère de la Guerre
Maps Collection
Louisiana Research Center, Tulane University (LRCTU)
  Charles Cassidy Bass Papers
  Charles Rouseve Papers
  Charity Hospital Inventory
  Council of Social Agencies of New Orleans Records
  Edgar B. Stern Collection
  Edmond Souchon Papers
  Hale Boggs and Lindy Boggs Papers
  Henry Dickson Bruns Papers
  John Minor Wisdom Collection
  Joseph Jones Papers
  Le Gardeur and Montegut Families Papers
  Medical Documents Collection
  New Orleans Social Council Collection
  Orleans Infirmary Papers
  Orleans Parish Medical Society Collection (OPMS)
  Rosemonde E. & Emile Kuntz Collection
  Rudolph Matas Papers
  Société Française Records
  Stanford E. Chaille Papers
  Tulane University Hospital Collection
  United States Marine Hospital Records
Louisiana State Archives
State of Louisiana Department of Health and Hospitals Records

Louisiana State Museum Historical Center (LSMHC)
- Antebellum Period Collection
- Charity Hospital Papers
- Frances B. Johnston Photographs Collection
- Master Calendar Collection
- Records of the French Superior Council in New Orleans

National Archives and Records Administration (NARA)
- Records of the Bureau of Refugees, Freedmen, and Abandoned Lands

Notarial Archives

Rudolph Matas Library of the Health Sciences, Tulane University (RMTU)
- Charity Hospital Records
- Medical College of Louisiana Records

Southeastern Architectural Archive, Tulane University
- James R. Lamantia, Jr. Office Records and Collection
- Leon Francis Dufrechou Office Records
- Miscellaneous Photographs Collection
- Rathbone DeBuys Office Records
- Robert Mills Papers
- Sanborn Fire Insurance Maps Collection
- Theodore Lilenthal New Orleans Photographs Collection

State Library of Louisiana
- Louisiana Works Progress Administration Collection

University of North Carolina at Chapel Hill Library
- Oral Histories of the American South Collection
APPENDIX B: PRIMARY SOURCE PERIODICALS

Chicago Defender
Congress Reports
The Crisis
DeBows Journal
Journal of the American Medical Association
Journal of the National Medical Association
Louisiana Board of Health Annual Report
Louisiana Weekly
New Orleans Medical News and Hospital Gazette
New Orleans States-Item
Pittsburgh Courier
Public Health Bulletin
Public Health Reports
The Saturday Evening Post
Southern Christian Advocate
Southwestern Christian Advocate
St. Tammany Farmer
Times Picayune
Transactions of the American Medical Association
Transactions of the American Surgical Association
Who's Who of the Colored Race
APPENDIX C: COURT CASES

Buchanan v. Warley, 245 U.S. 60 (1917)

Cook v. Ochsner Foundation Hospital, 61 F.R.D. 354 (E.D.La.1972)

Harmon v. Tyler, 273 U.S. 668 (1927)

The Josefa Segunda, 18 U.S. 5 Wheat. 338 338 (1820)

Thurman et. al v. Nagin, Civil District Court for the Parish of Orleans 09-7244 (2009)

United States v. Preston, 28 U.S. 3 Pet. 57 57 (1830)
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Rudwick, Elliot M. "A Brief History of Mercy-Douglass Hospital in Philadelphia." *The


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Thomas, Lynn L. *Disaster and Desire in New Orleans: Tourism, Race, and Historical*
Wells-Barnett, Ida B. Mob Rule in New Orleans: Robert Charles and His Fight to Death,
the Story of His Life, Burning Human Beings Alive, Other Lynching Statistics.
Chicago, 1900.