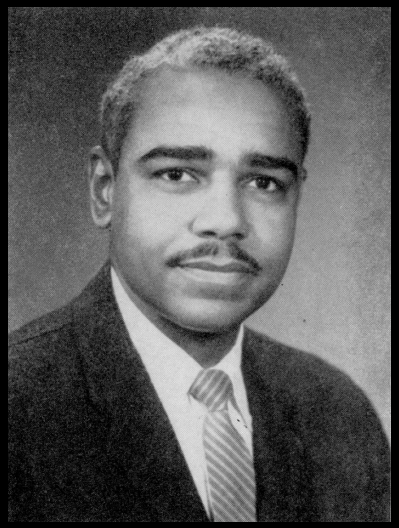
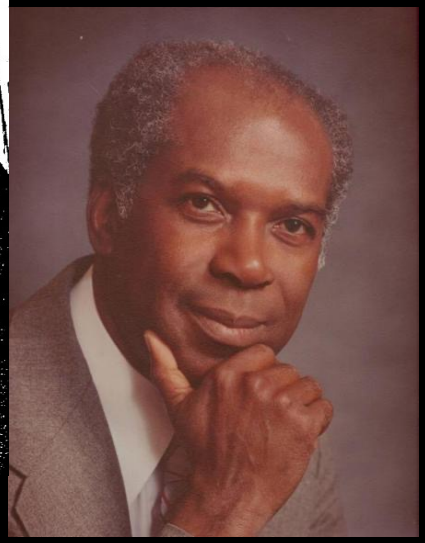
Martin Luther King Jr. General Hospital + Charles R. Drew Postgraduate Medical School
Los Angeles County's Third and California's Last Public Hospital (Planned 1965, Opened 1972)





Session Overview

Part I:
History of Hospitals and Doctoring in Los Angeles until 1965
Hospitals and doctoring from the perspective of the County's white city boosters

Part II:
History of Hospitals and Doctoring in Los Angeles until 1965
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Part III:
Suturing Racial Divides through King-Drew Medical Center
Visions for hospitals and doctoring at the twilight of Jim Crow/Civil Rights

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Learning Outcomes

By exploring this history,
We will illuminate how the relationships between race, labor, and place (real estate) shape doctoring

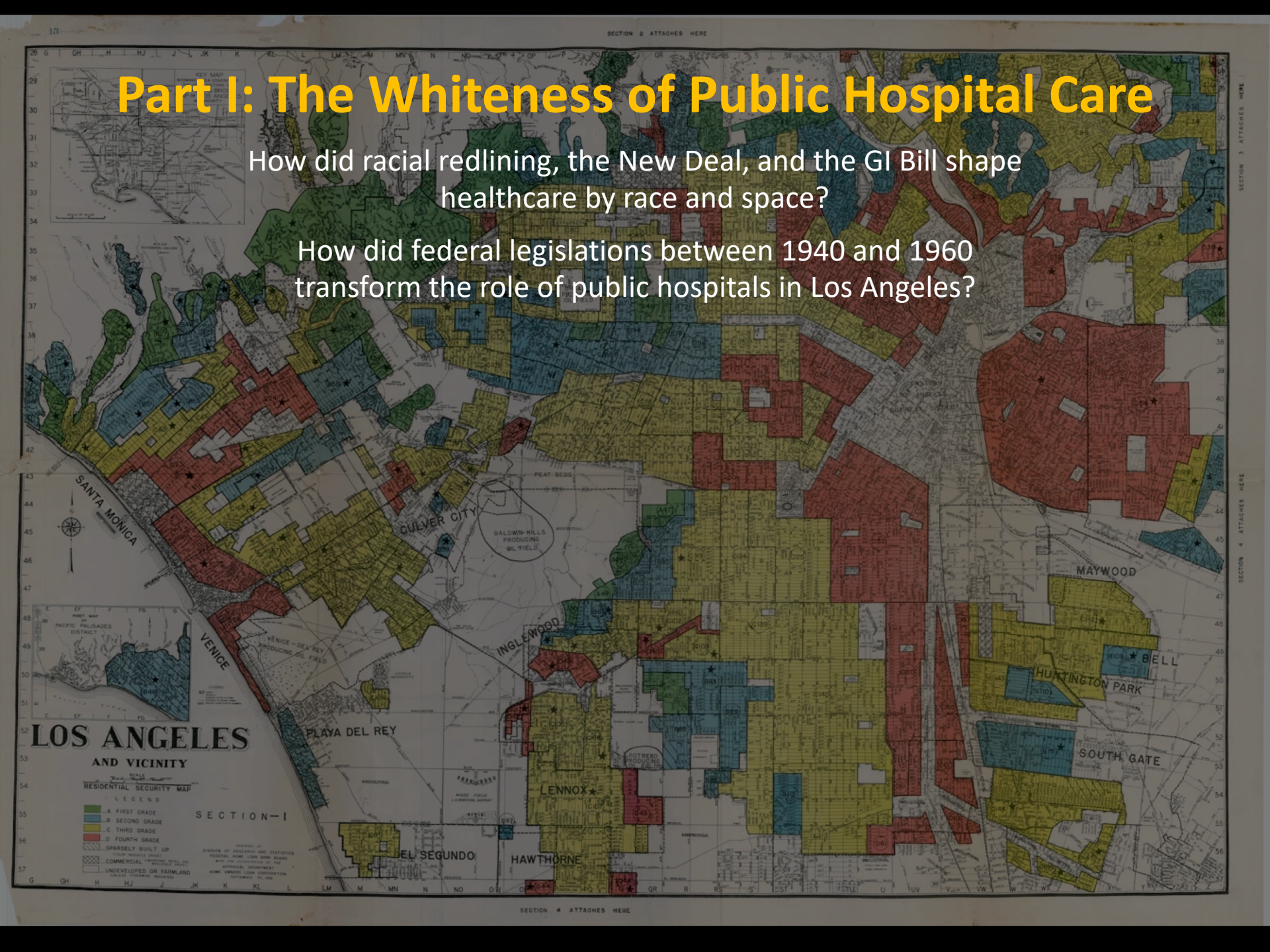
By exploring this history,
We will also investigate the stigma that doctors of color face when they choose careers as specialists or as 'community' physicians after they finish their training

Exploring this history,
- Will also help you understand why some patients automatically assume that the "doctor" or "expert" in the room is anyone who is white and male (and conversely, not a person of color, a trans/non-binary person, or a woman)
- Will help you understand why some patients may be hesitant or skeptical of the care they are receiving from you
- Will help you understand how race and class structure the "patient populations" of hospitals based on the stratification of healthcare in the built landscape

Part I: The Whiteness of Public Hospital Care

How did racial redlining, the New Deal, and the GI Bill shape healthcare by race and space?

How did federal legislations between 1940 and 1960 transform the role of public hospitals in Los Angeles?



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- How federal legislation and local practices made most Black patient populations a "fungible" subject within healthcare by making their bodies, sickness, and suffering valuable for the medical establishment for research, training, and experimentation on the medical establishment's terms but not valuable for anything else.
- How federal legislation and local practices marginalized Black physicians by rendering their practices and skills as always inferior to white male physicians and by leaving them to practice in neighborhoods considered by most white physicians to be "too poor and too Black" to make a decent living as a doctor.

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“Rooted in white patriarchy and affluent supremacy”

Examining the American Medical Association’s racist history and its overdue reckoning

May 18, 2021 6:30 PM EST

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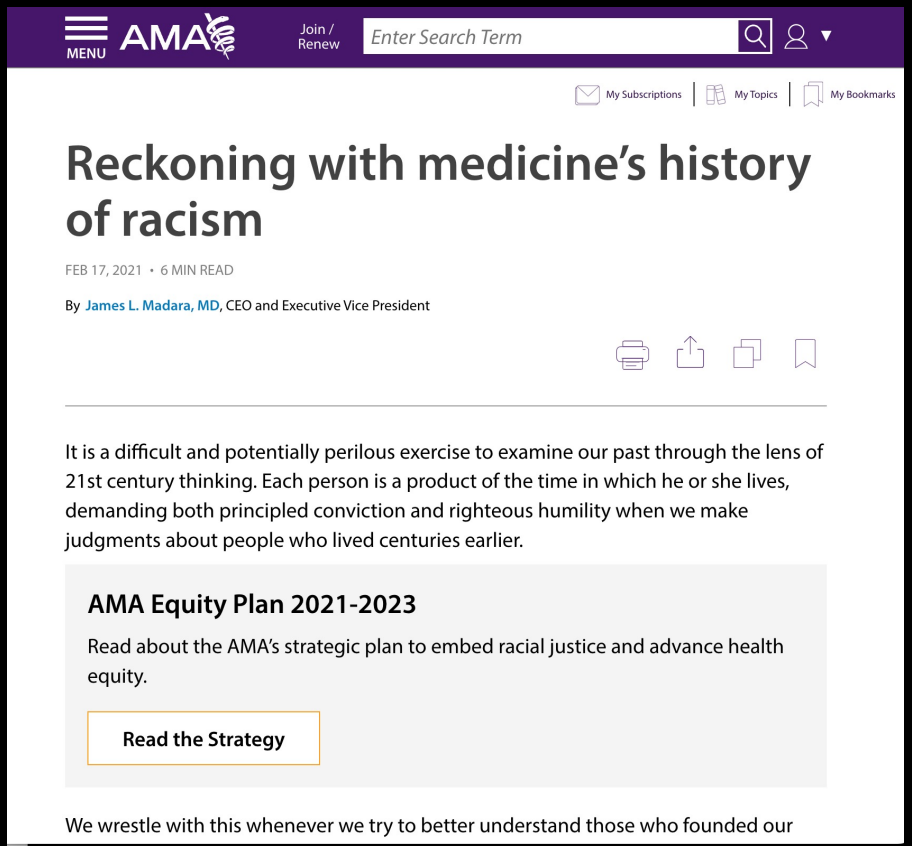

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Reckoning with medicine’s history of racism

FEB 17, 2021 • 6 MIN READ

By James L. Madara, MD, CEO and Executive Vice President

It is a difficult and potentially perilous exercise to examine our past through the lens of 21st century thinking. Each person is a product of the time in which he or she lives, demanding both principled conviction and righteous humility when we make judgments about people who lived centuries earlier.

AMA Equity Plan 2021-2023

Read about the AMA’s strategic plan to embed racial justice and advance health equity.

Read the Strategy

We wrestle with this whenever we try to better understand those who founded our

Racial exclusion of Black providers and aspiring providers was a hallmark of the American Medical Association’s founding

But, this logic of exclusion, through race and by racial “proxies,” continued to structure who counted as a physician well after membership in the AMA no longer exclusively made a doctor, a doctor. By the 1930s, a doctor increasingly meant having a:

- Medical Diploma
- State License
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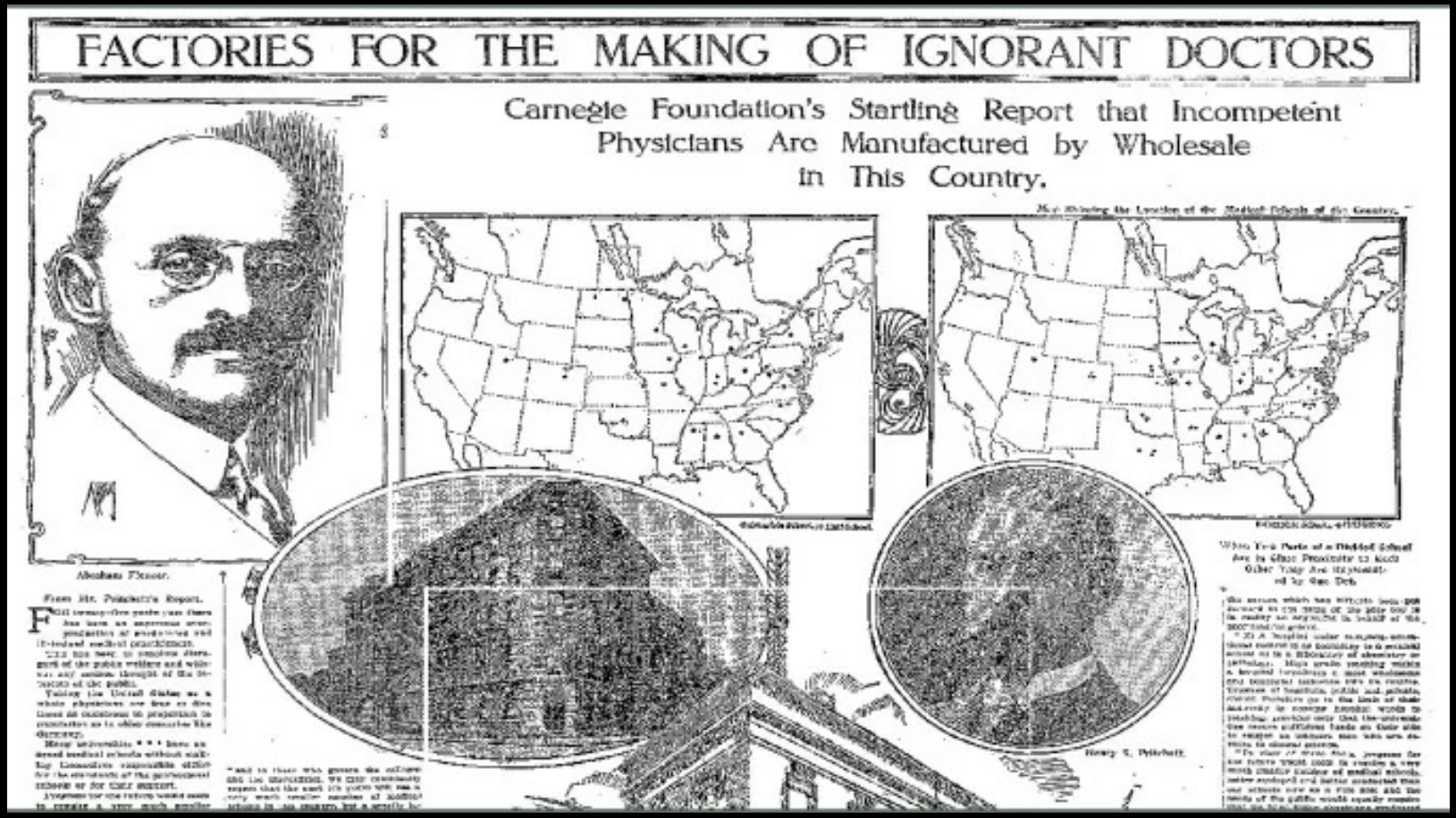
Most narratives describe these elements of doctoring as necessary for “scientific progress” but they are also signs of how white medical leaders moved the milestones associated with being a doctor by normalizing new “standards” that were difficult for Black activists and their allies to keep up with.

“Rooted in white patriarchy and affluent supremacy”



FACTORIES FOR THE MAKING OF IGNORANT DOCTORS

Carnegie Foundation's Startling Report that Incompetent Physicians Are Manufactured by Wholesale in This Country.

Abraham Flexner.

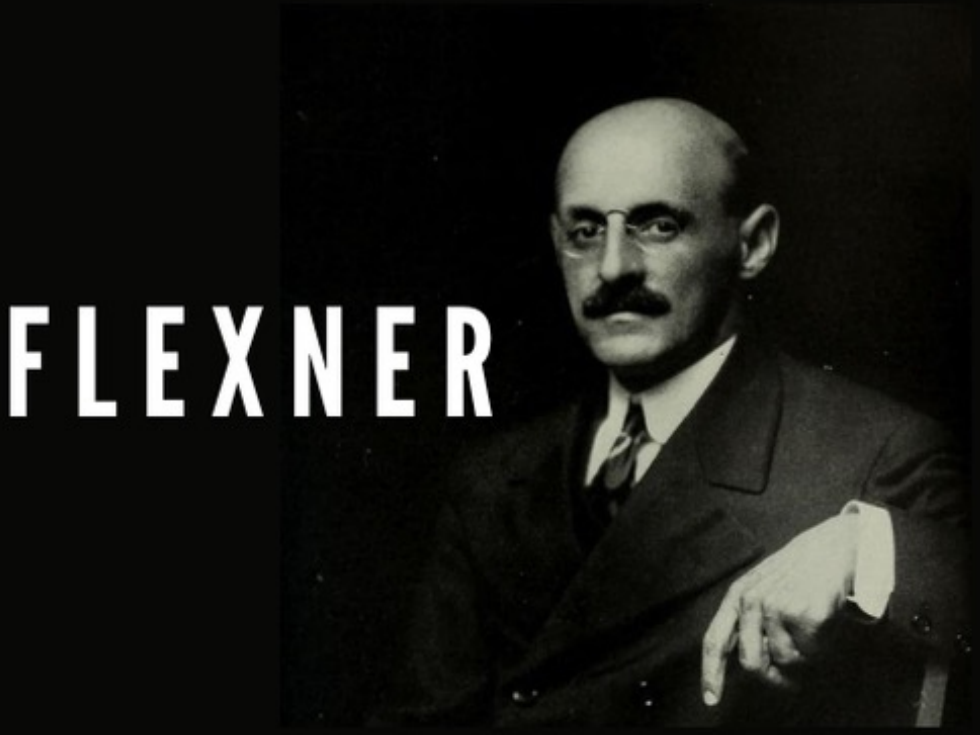
From Mr. Pritchett's Report.

Henry S. Pritchett.

The Flexner Report of 1917 shrank the number of medical schools to those schools rich enough and big enough to afford teaching and training in laboratory medicine

“Rooted in white patriarchy and affluent supremacy”

Flexner whittled down the number of medical schools from 148 to 66
Of 7 Black medical Schools, only two remained: Howard and Meharry



The report empowered many White Medical Schools to think of the Flexner Report as permission to segregate medical education

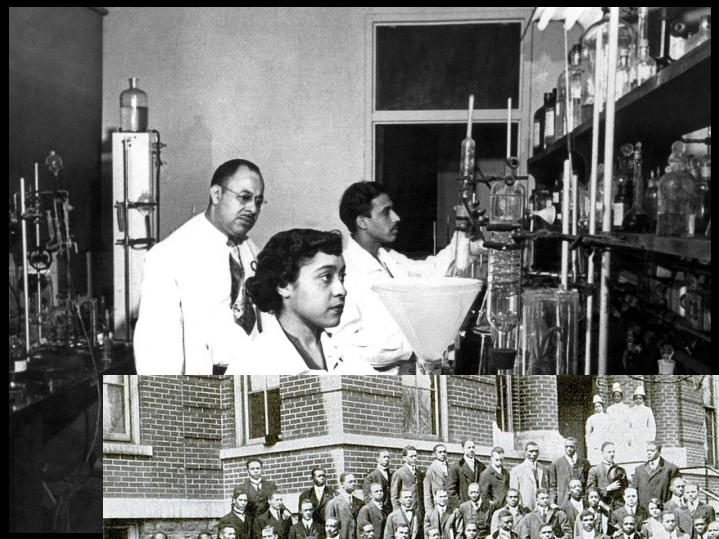
Flexner also encouraged Howard and Meharry to focus on producing Black “sanitarians” so as to not have Black doctors who competed with white doctors

The effect of the Report help ratify the idea that all Black doctors were inherently inferior physicians, by training and/or on account of their supposed racial inferiority

“Rooted in white patriarchy and affluent supremacy”

The combination of these factors bred a culture of white supremacy within medicine that not only positioned the care and services of a white physician as always more desirable than a Black physician but also bred a belief that all patients, *especially Black* patient populations, were a “property” of white physicians to use – either as an economic supplement to white patient populations OR to use for research, training, experimentation to improve upon skills, methods, and procedures.

“Rooted in white patriarchy and affluent supremacy”



Black physician activists and their allies mostly working in the National Medical Association, by the 1930s, sought to fight the racism of these structures by implementing efforts to biomedicalize training at Howard and Meharry and by securing a range of internships in Black hospitals to match the training of most white physicians.

“Rooted in white patriarchy and affluent supremacy”

By the 1930s, being a “good doctor” meant having a:

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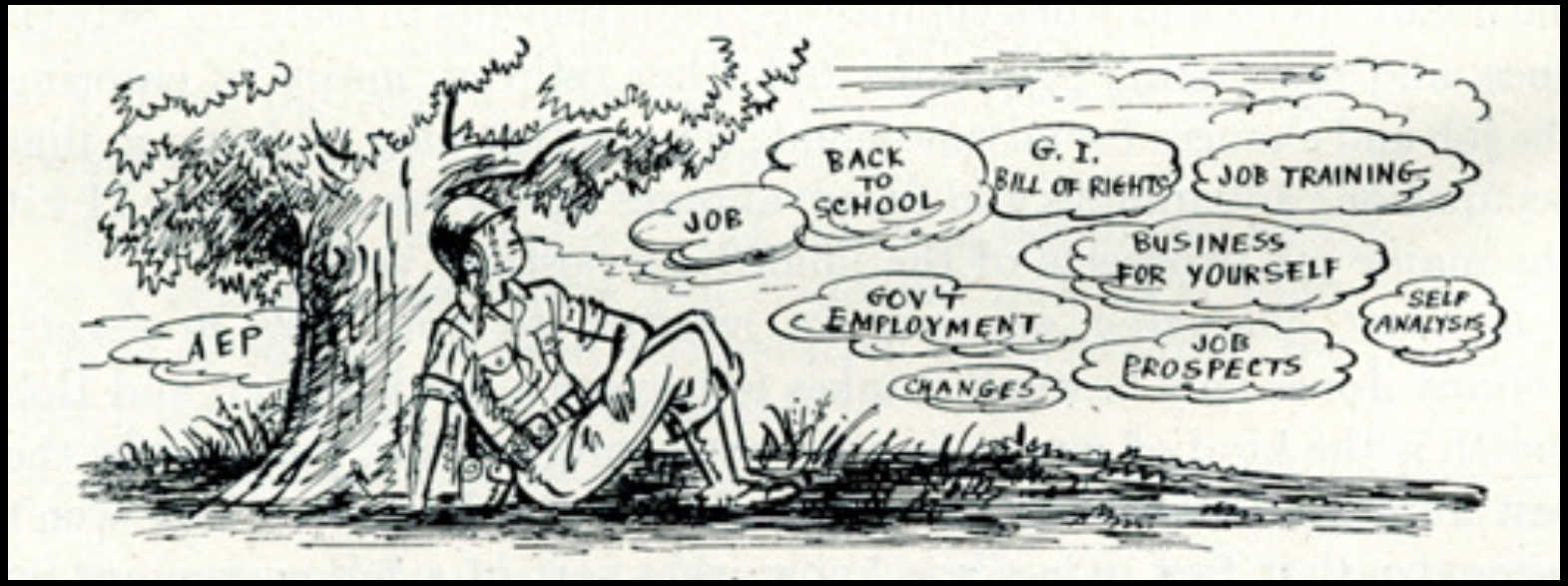

“Rooted in white patriarchy and affluent supremacy”

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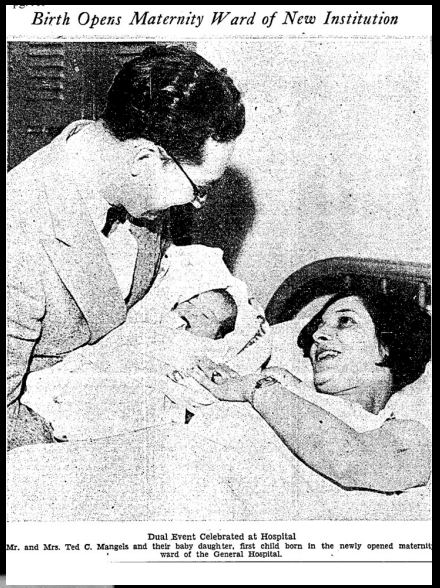
Federal programs almost entirely by-passed Black workers because the federally-funded programs associated with the postwar's redistribution of wealth were locally administered by local actors. A whole host of private and public agents entrusted to carry out federal programs – such as social workers, real estate agents, job center leaders, bank officers, higher education admission officers, and union leaders – all used their discretionary power to arbitrarily deny people of color benefits that they were legally entitled and eligible to receive.

“Rooted in white patriarchy and affluent supremacy”

The county provides “a type of facility comparable to the Mayo Clinic or the Johns Hopkins Hospital” – Lawyer for John Anson Ford, Los Angeles County Supervisor 1938



Birth Opens Maternity Ward of New Institution

Dual Event Celebrated at Hospital
Mr. and Mrs. Ted C. Mangels and their baby daughter, first child born in the newly opened maternity ward of the General Hospital.

AT THE COUNTY HOSPITAL.

A Large Attendance of Visitors, and Creditable Exercises.

In our County Hospital there are about 75 patients, many of whom have been noted pioneers on this coast. As they are not able to attend the city celebrations, it was determined that they should have a "Fourth of July" of their own. The residents of the institution

pg. II22

CHILDBIRTH HOSPITAL IS COUNTY AIM

Separate Rooms Planned for Ill Children Under Proposed Bonds

A modern maternity hospital and a children's hospital, adequate for the needs of the growing community, are part of the county's health program as outlined by the Board of S
"I
if t
May
Bea
ing
will
whe
and have the best of care."

The building, as planned, will contain separate quarters for a children's hospital where the children

These bonds must be voted through or we will lose the right to our pride in the "great white spot."
MRS. M. M. JAMES.

pg. 10

Scores of Babies Saved by County's Medical Care

General Hospital Report Discloses Death Rate at Birth Being Reduced

BY ED AINSWORTH

Exactly 185 husky babies are crawling around on the f
sticking their toes in their mouths today in Los Angeles
because they picked the right year in which to be born.

If they had appeared five years earlier they now w
resting quietly beneath 185 little headstones in the stil
some grassy cemetery.

That's just one picture which
flashes out of a mass of medi
cal material just compiled by
the Los Angeles County Hospi
tal and released by Dr. P. Ber
man, medical director.

STORY IN STATISTICS

In the report, human lives and

birth that has come to be
as the Caesarian sectio
popularity of this p
entrance into worldly a
shown by the fact that
eight babies were born t
last year and that all b
of them lived. Forty-two
themselves of an ultra-modern better chance to come out alive.

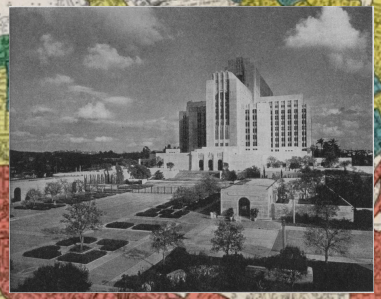
ratio had been maintained in 1935-36, the death toll among babies would have been 498. This means that the difference between 313 and 498—a total of 185—is alive today because of

aid before they even passed through the hospital door.

NEXT WORST DANGER

Next worst day of danger is the third, when 10.1 per cent of

The workers charged the company, flooded with admiralty orders as part of Great Britain's $7,500,000,000 rearmament program, violated a union agreement by transferring two men

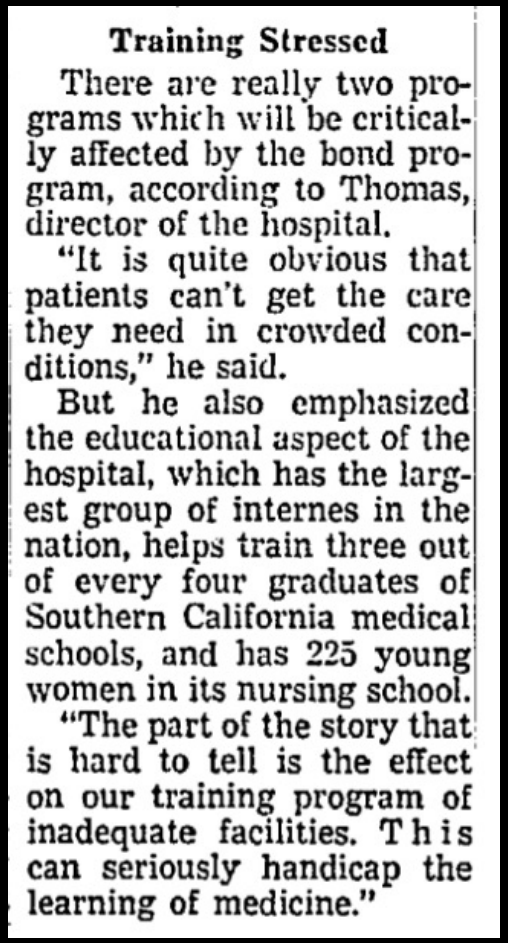


White flight fuels private

“Rooted in white patriarchy and affluent supremacy”

A (White) Physician’s Journey

Train in Public Hospital “downtown” to Work and Retire in a Private Suburban Hospital



Training Stressed

There are really two programs which will be critically affected by the bond program, according to Thomas, director of the hospital.

“It is quite obvious that patients can’t get the care they need in crowded conditions,” he said.

But he also emphasized the educational aspect of the hospital, which has the largest group of internes in the nation, helps train three out of every four graduates of Southern California medical schools, and has 225 young women in its nursing school.

“The part of the story that is hard to tell is the effect on our training program of inadequate facilities. This can seriously handicap the learning of medicine.”

Furthermore, the social attitudes of the health professionals reflect too frequently the notion still prevalent among medical teachers and administrators that the poor who obtain their care in public, especially teaching, institutions are "*clinical material*."

These new resulting relationships produced white physicians for white populations by holding communities of color, as California Director of Public Health Dr. Lester Breslow phrased it, as captive "clinical material" for medical schools to use as subjects to train doctors and to innovate medicine with.

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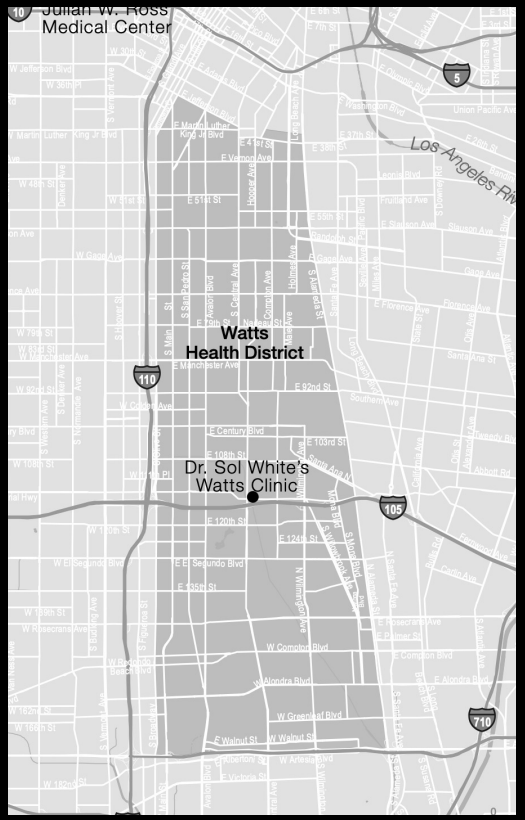
These new resulting relationships produced white physicians for white populations by holding communities of color, as California Director of Public Health Dr. Lester Breslow phrased it, as captive "clinical material" for medical schools to use as subjects to train doctors and to innovate medicine with.

These new relationships also expanded the types of medical services for white patients beyond the "general practitioner" to include all types of specialists and services at primary, secondary, and tertiary levels (something that we now to refer to as "comprehensive medicine") while limiting the kinds of services to poor patient populations to just those found in the public hospital.

Part II: To Live and Doctor in LA

How did racial redlining, the New Deal, and the GI Bill shape healthcare by race and space?

How did nation-wide discrimination against Black physicians in medical school admissions, training, and private practice shape opportunites for Black doctors in Los Angeles?



Across street from his office, Dr. White stands on spot where store formerly stood before fiery Watts riots last year.

Children line his office and await turn for checkup as affable pediatrician checks boy's ear for possible infection.

Small patient doesn't care too much for physician's stethoscope —proceeds to loudly voice his displeasure. Doc weighs boy.

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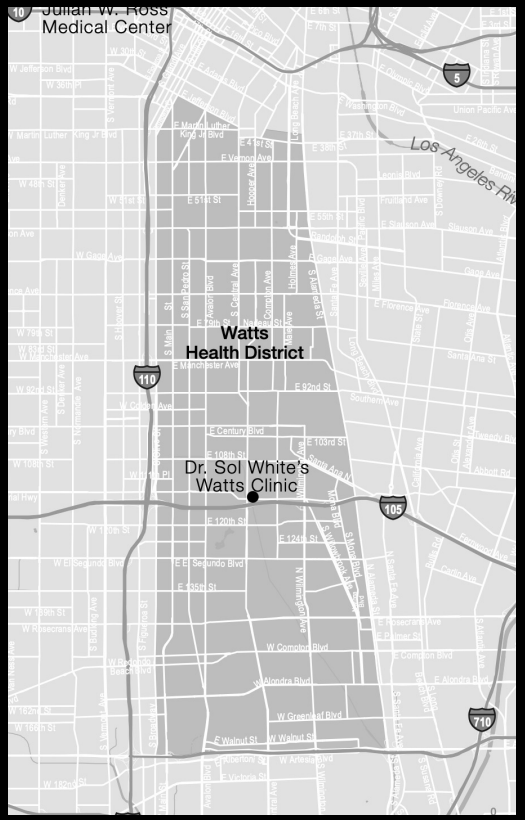

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In this second section, we will be examining historical data (via maps and historical data sets) to:

- Appreciate the challenges Black physicians faced in obtaining a medical degree and doctoring while Black
- Gain eyesight into how residential and employment discrimination shaped access to healthcare for Black residents

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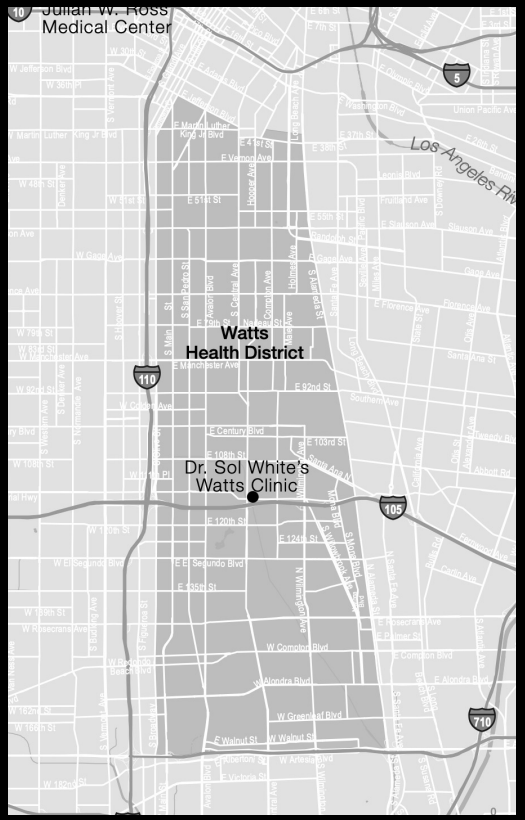

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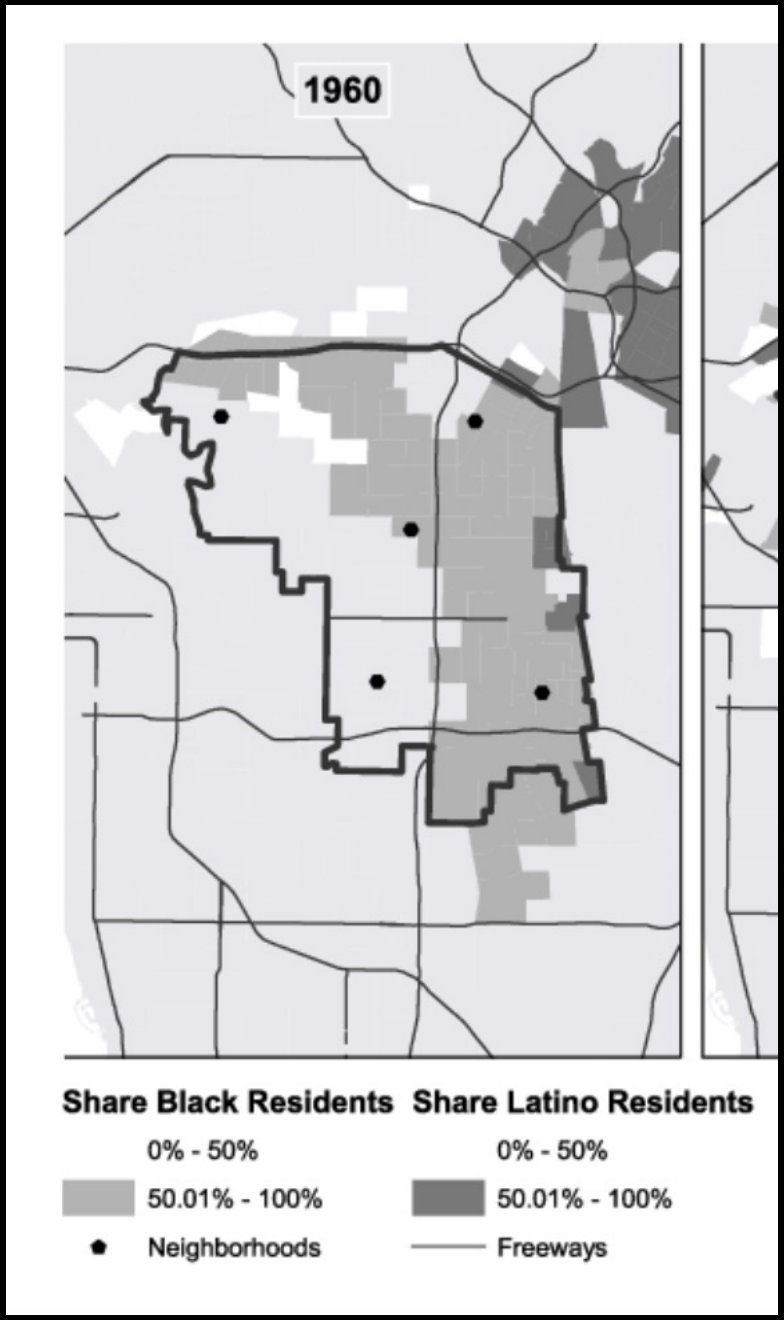
The Geography of the Great Migration

The Migration of African Americans from the American South (1910-1970)



“White flight” hemmed in many Black migrants into a select number of neighborhoods in South Los Angeles but “white flight” also took many of the jobs that were concentrated in the city to the suburbs by the 1960s.

Instead of find jobs and income security, many Black residents after the war economy subsided found themselves increasingly in low-paying jobs that required lots of travel or found no jobs at all.

The Distribution of Black Physicians in the United States, 1967

M. ALFRED HAYNES, M.D.
Executive Director, National Medical Association Foundation

DISTRIBUTION OF BLACK PHYSICIANS BY SCHOOL OF GRADUATION

Table 1 indicates that 83 per cent of the 4,805 black physicians graduated from Howard University and Meharry Medical College. All other United States medical schools combined graduated only 15 per cent.

TABLE 1.—DISTRIBUTION OF BLACK PHYSICIANS BY SCHOOL OF GRADUATION, 1967.

School	*Total*	*Per Cent*
Total Graduates	4,805	100.0
Howard University College of Medicine	2,186	45.5
Meharry Medical College	1,822	37.9
All other U. S. schools	726	15.1
Canadian medical schools	19	0.4
Foreign medical schools	52	1.1

TABLE 2.—PREDOMINANTLY WHITE MEDICAL SCHOOLS RESPONSIBLE FOR TRAINING MORE THAN 20 BLACK GRADUATES

University of Illinois College of Medicine	57
University of Michigan Medical School	48
Wayne State University School of Medicine	38
Indiana University School of Medicine	35
Ohio State University College of Medicine	30
New York University School of Medicine	27
Harvard Medical School	23
Northwestern University Medical School	22
Loma Linda University School of Medicine	22
Chicago Medical School	21

Problems Facing the Negro in Medicine Today

M. Alfred Haynes, MD

I have been asked to touch briefly on the whole area which we will cover today: the problems facing the Negro today, first as a medical student, then in postgraduate training, and finally in actual practice.

The Medical Student

Much progress has been made, especially in recent years, but many problems still face the Negro in medicine today. A few years ago, the black applicant to medical school was fairly limited in his choice. He applied to Howard University and to Meharry Medical College. If he applied elsewhere, it was really an act of courage because he knew that his chances were fairly slim. Today the average black student still makes a smaller number of applications than the average white student, but the situation is somewhat different. If he is a brilliant and exceptional student, he may be sought after, courted, seduced, bought, and before he knows it, actually auctioned to the highest bidder in a fierce, competitive market of predominantly white schools looking for black students.

For most black students, this will not be the case. The average one is more than likely to have scored below the 50th percentile in the Medical College Admissions Test (MCAT). His performance is likely to be below that of many other applicants to predominantly white schools. The educational opportunities at the school he attended are likely not to have been as rich as those of his white counterpart. All of this is the product of many years of educational disadvantage, which may have accumulated to such a point that by the end of college his chances of selection to medical school have been reduced academically to one tenth or less that of the average white student. In general then, black students cannot, at the present time, be measured by the same standards. Until the educational handicaps are removed, beginning from the elementary level, black students will always be at a disadvantage. But this does not mean that they have not, and will not, become great doctors. We recognize that stu-

From the Department of International Health, Johns Hopkins University School of Hygiene and Public Health, Baltimore; and the National Medical Association Foundation, Inc., Washington, D.C.

Read before the 65th annual Congress on Medical Education, sponsored by the AMA Council on Medical Education, Chicago, Feb 9, 1969.

Reprint requests to Suite 403, 1000 16th St NW, Washington, DC 20006 (Dr. Haynes).

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...ernational Health, Johns Hopkins ...and Public Health, Baltimore; and ...tion Foundation, Inc., Washington,

...al Congress on Medical Education, ...ncil on Medical Education, Chicago,

...03, 1000 16th St NW, Washington, DC

The Distribution of Black Physicians in the United States, 1967

M. ALFRED HAYNES, M.D.

Executive Director, National Medical Association Foundation

DISTRIBUTION OF BLACK PHYSICIANS BY SCHOOL OF GRADUATION

Table 1 indicates that 83 per cent of the 4,805 black physicians graduated from Howard University and Meharry Medical College. All other United States medical schools combined graduated only 15 per cent.

TABLE 1.—DISTRIBUTION OF BLACK PHYSICIANS BY SCHOOL OF GRADUATION, 1967.

School	*Total*	*Per Cent*
Total Graduates	4,805	100.0
Howard University College of Medicine	2,186	45.5
Meharry Medical College	1.822	37.9
All other U. S. schools	726	15.1
Canadian medical schools	19	0.4
Foreign medical schools	52	1.1

TABLE 2.—PREDOMINANTLY WHITE MEDICAL SCHOOLS RESPONSIBLE FOR TRAINING MORE THAN 20 BLACK GRADUATES

University of Illinois College of Medicine	57
University of Michigan Medical School	48
Wayne State University School of Medicine	38
Indiana University School of Medicine	35
Ohio State University College of Medicine	30
New York University School of Medicine	27
Harvard Medical School	23
Northwestern University Medical School	22
Loma Linda University School of Medicine	22
Chicago Medical School	21

What's the Problem with the medical admission practices of predominantly-white medical schools? Why, in Dr. Haynes's opinion, are predominantly-white medical students who admit Black medical students not exempt from racism?

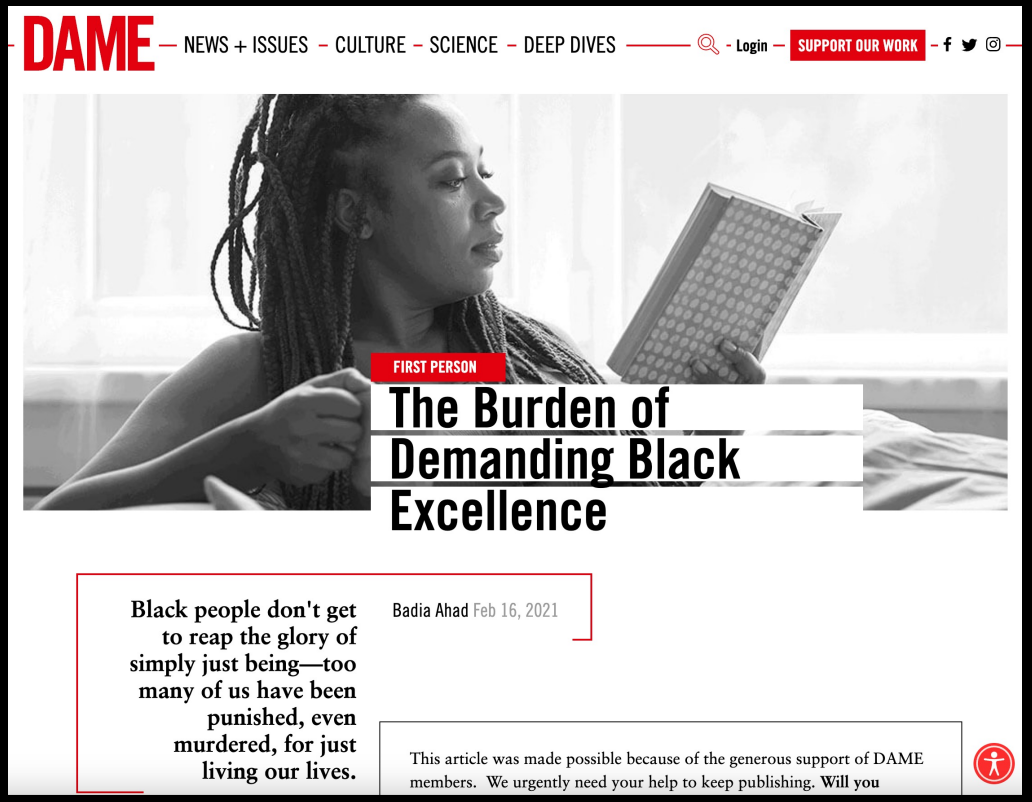
Haynes's comments demonstrates that Black physicians had already developed a sophisticated way of understanding divisions amongst Black physicians based on their graduating institutions.

He argues that education and recruitment practices transformed a small subset of Black students in predominantly-white institutions into a sort of "model minority" subjected to a myriad of expectations of excellence related to racial representation

OR

into a set of Black students stigmatized as inferior because of the lack of resources found in many Black schools.

He implies that Black students are subjected to ideas of "excess" (being too smart) or lack (being too 'dumb') that are often unfair and out of their control.



Problems Facing the Negro in Medicine Today

M. Alfred Haynes, MD

Black students have another problem. They are the objects of another subtle form of racism. Many institutions are willing to train black students for the ghetto but other students are expected to enjoy a free choice. It is true that black physicians are providing much of the health care for the black ghetto, but the health of ghetto residents is everyone's responsibility. Teaching institutions have an obligation to inform students of the complex health problems of the ghetto and to challenge them towards effective solutions. This obligation cannot be met by accepting a few black students and hoping that they will practice only in the ghetto.

I'll add that many Black medical leaders supported the creation of elite medical school pipelines in predominantly-white medical schools, especially when it came to postgraduate medical training. Howard University leaders, for instance, with the help of the Rosenwald Fund and Ford Foundation, began sending the most exceptional Black medical graduates to predominantly-white medical schools to train as specialists so that they could return to build postgraduate medical programs at Howard.

In addition to being the first black dean, Dr. Numa P. G. Adams is remembered for his leadership in developing a medical school faculty that was second to none. He did this largely by recruiting the ablest young black faculty he could find and sending them away for two years of advanced training at prestigious universities and hospitals around the country. This program was funded by grants from the General Education Board established by the Rockefeller Foundation. Among the twenty-five individuals to receive advanced fellowship training through the General Education Board were Dr. Montague Cobb, who earned his Ph.D. at Western Reserve University in Cleveland and Dr. Charles Drew, who earned the D.Sc. degree from Columbia University. In the fall of 1938, Dr. Drew was sent to Columbia by Dr. Adams to work with Dr. Allen O. Whipple, one of the leading surgeons of his day. Whipple assigned Dr. Drew to work with Dr. John Scudder, whose research team was studying fluid balance, blood chemistry, and blood transfusion. Dr. Drew's doctoral dissertation under Dr. Scudder was entitled "Banked Blood: A Study in Blood Preservation." When the Blood for Britain Project needed a full-time medical supervisor in 1940, Dr. Drew was eminently qualified for the position.

Howard University History by Sterling M. Lloyd, Jr.

The Distribution of Black Physicians in the United States, 1967

M. ALFRED HAYNES, M.D.
Executive Director, National Medical Association Foundation

TABLE 3.—DISTRIBUTION OF NMA PHYSICIANS BY REGION AND STATE, 1967

Division State	*Total NMA Members*	*Division State*	*Total NMA Members*
Total Physicians 4,805			
New England	93	East South Central	275
Connecticut	41	Alabama	61
Maine	3	Kentucky	37
Massachusetts	43	Mississippi	44
New Hampshire	0	Tennessee	133
Rhode Island	6		
Vermont	0	West South Central	244
		Arkansas	17
Middle Atlantic	976	Louisiana	62
New Jersey	178	Oklahoma	30
New York	562	Texas	135
Pennsylvania	236		
		Mountain	29
East North Central	921	Arizona	12
Illinois	265	Colorado	8
Indiana	99	Idaho	0
Michigan	270	Montana	0
Ohio	256	Nevada	3
Wisconsin	31	New Mexico	5
		Utah	0
West North Central	197	Wyoming	1
Iowa	12		
Kansas	23	Pacific	598
Minnesota	19	Alaska	0
Missouri	135	California	574
Nebraska	7	Hawaii	4
North Dakota	1	Oregon	6
South Dakota	0	Washington	14
South Atlantic	1084	Possessions	22
Delaware	11	Puerto Rico	11
District of Columbia	417	Virgin Islands	11
Florida	82		
Georgia	86	Address Unknown	84
Maryland	163		
North Carolina	130	Overseas	262
South Carolina	45		
Virginia	138	Foreign Countries	20
West Virginia	12		

If the only two Black medical schools located in United States were located in Washington, D.C. and in Nashville, what's surprising about the three places with the highest concentrations of Black physicians? What might account for this distribution?

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Of the three largest concentrations for Black physicians in the United States (DC, California, and New York), two are not in the South and both were nowhere near a Black medical school. This data shows that most Black physicians did not practice in the South but joined other Black migrants in moving north and west. This reflects the hope that the higher wages of cities would offer more opportunities for Black physicians to make money and have the freedom to practice without fear of white vigilante violence.

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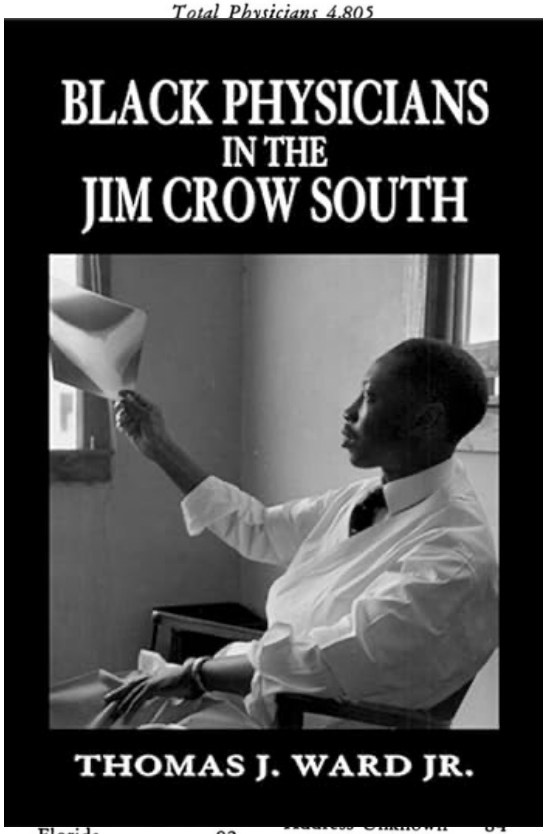

As Thomas Ward, Jr. has shown, many Black physicians in the South faced hostility from physicians who claimed local Black rural populations as their clients. While this hostility sometimes arose from competition from another Black physician, most of the time it was hostility from white physicians who were unafraid of using violence to enforce their claims to patient populations. The fact that Southern communities were often poorer and more widely spatially spread apart also account for why fewer physicians practiced in the South.

Black physicians were especially drawn to cities because the concentration of so many Black working class families helped cultivate a paying Black middle class clientele that was often larger and wealthier than those found in the South.

Table 2.1 Map of Hospitals Included in the Special Study of South and Southeast Los Angeles Metropolitan Area

Source: Hospital Planning Association Report, December 14, 1965, Kenneth Hahn Collection Box 200, Folder 1 (Special Collections, Huntington Library)

Figure 2.2 Twenty Closest Selected Hospitals to Watts Health District, 1965

Twenty Closest Selected Hospitals to Watts Health District, 1965

Hospitals Inside Watts Health District			*Hospitals Outside Watts Health District*		
Name	Licensed Acute Beds	Accredited	Name	Licensed Acute Beds	Accredited
Avalon	22	No	Broadway	67	Yes
Oak Park	43	No	Suburban	39	No
Bon Air	42	No	Orthopedic	162	Yes
Gardena	75	No	John Wesley	259	Yes
Las Campanas	6	No	Doctor's	63	No
			Civic Center	36	No
			University	49	Yes
			South Hoover	32	No
			St. Francis	428	Yes
			Community of Huntington Park	77	Yes
			Soto	7	No
			Mission	129	Yes
			Morningside	86	Yes
			Community of Gardena	55	Yes

Source: Hospital Planning Association Report, December 14, 1965, Kenneth Hahn Collection Box 200, Folder 1 (Special Collections, Huntington Library)

What do these data sets say about who most hospital owners in Los Angeles sought to serve? What might be said of those hospitals located inside Black neighborhoods?

Table 2.1 Map of Hospitals Included in the Special Study of South and Southeast Los Angeles Metropolitan Area

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These data sets show that hospital owners deliberately situated their businesses outside of the densest and poorest Black districts and sought to cultivate relationships that maximized the patronage of paying white families and paying Black middle class families by keeping their services specialized and/or exclusive. Hospitals inside the poorest densest Black neighborhoods all struggled to keep up with rising hospital standards. This is evident in the fact that ALL of hospitals inside the Watts Health District failed to achieve accreditation.

THE WATTS HOSPITAL:

A HEALTH FACILITY IS PLANNED FOR A METROPOLITAN SLUM AREA

by

Arthur J. Viseltear, Ph. D., Assistant Research Historian,

Arnold I. Kisch, M.D., Assistant Professor of Medical Care Organization,

and

Milton I. Roemer, M.D., Professor of Public Health,

all of the University of California, Los Angeles, California

(which is larger than the South and Southeast Health Districts, although not entirely inclusive of them). These hospitals range from 22 to 136 beds in capacity, with a total of 454 beds. Of the eight, only two are approved by the Joint Commission on Hospital Accreditation.

The generally poor quality of patient-care in the South-Southeast District proprietary hospitals has been noted in hospital licensing reports by the California State Department of Public Health. In one hospital, a 1964 report ordered that the kitchen be cleaned, mice-droppings be removed, infected dressings be incinerated, a registered nurse be on duty for the 11 P.M. to 7 A.M. shift, and the physician sign medication orders -- all recommendations reflecting serious deficiencies in the hospital. In another hospital, the official report called for disposal of garbage in proper containers, the storage of drugs and poisons separately from foods, and the recording of infant formulas on charts. In another hospital, the report indicated cockroach infestation near the coffee urns, torn or missing screens, no written manual of maternity nursing procedures, and inoperative signals to call the nurses.

Two additional hospitals which meet accreditation standards are located on the northern edge of the territory, but do not serve general medical purposes. One is the Orthopedic Hospital, providing care for bone and joint disorders. The other, the 253-bed John Wesley Hospital (under Los Angeles County government), cares mostly for maternity cases.

The neighboring community of Lynwood contains the St. Francis Hospital, an accredited 530-bed institution. This nonprofit hospital does not operate an organized outpatient service, and receives only emergencies or private patients referred by its staff doctors. Of the 235 physicians with active staff

Compton Post

VOL. VIII — No. 24 — Wednesday, May 4, 1966

A Post Editorial

Vote For 'A' Need

There are two basic things in life necessary for the survival of man. One is food. The other is medical care. Every person, rich or poor, educated or uneducated, catholic or otherwise, is entitled to both of those basic needs.

Few people will refuse his neighbor some kind of assistance if his neighbor is hungry or sick.

Our neighbors to the northwest, Willowbrook and Watts, have dire need for a hospital facility. Proposition "A" on the June 7 primary ballot will, if passed, provide the funds to give our neighbors a 438-bed hospital.

The County Board of Supervisors, after much thought and discussion, has placed proposition "A" before the voters asking approval of a $12,300,000 bond issue to build the $21.4 million county hospital. Federal funds will pay the $9.1 million difference.

Far less persons in the Watts area can afford private hospitalization than those of any other area around. Far less of them can afford "road-worthy" autos to transport them to L.A. County General or Harbor General, both of which are 10 miles away from the area. Besides, both of these facilities are over crowded now. All of this was brought out by the McCone Commission report.

We are aware that bond issue upon bond issue will appear on the June ballot. And we are aware that taxpayers are "up to here" with tax burdens. However, children cannot play in public parks if they are sick. They cannot attend public schools if they are sick. Adults cannot support their families if they, themselves, are sick. Communicable disease and birth rates are high. County hospitals are as far away as two hours by bus from the Watts area. Any mother knows what two hours can mean in the case of childbirth or in the case of serious injury.

Costs are exclusive of site acqusition. Taxpayers with property assessed at $5,000 would find less than 40c per year added to the tax bill. A small amount to give for such a facility to a people who need it now.

Proposition "A" calls for less money than any other bond proposal, yet it will serve one of the most important needs. We believe the passage of this issue is the right thing to do. We are not voting for a luxury, we are voting for the life of many people. We urge a yes vote on Proposition "A", June 7.

THURSDAY, MAY 19, 1966

PROP. A: NEW HOSPITAL FOR WATTS

District Health Officer Points to Urgent Need

(This is the first in a series of articles on Proposition A, the $12.3 million bond issue on the June 7 primary ballot for construction of a public hospital in the Watts area—EDITOR)

By JERRY McLAIN
Copley News Service

LOS ANGELES — Dr. Geraldine Branch, district health officer in the Watts area, sometimes just shakes her head when pondering the problems forcing her.

She thinks of the 5-year-old boy who died recently of meningitis, and the explanation of the parents:

"We knew he was sick but didn't have enough money to take him to General Hospital on the bus."

Dr. Branch also recalls the heavy impact of the recent measles epidemic and the death of an area youngster from measles encephalitis.

She wonders about the two-hour waiting period sometimes for a General Hospital ambulance to arrive in her district for a critically ill person.

Half-Hour

"An ambulance is doing very well if it comes from General Hospital, 13 miles away, in a half-hour," she said.

And sometimes all of them are being used elsewhere.

It's for these reasons, and more, that Dr. Branch has considered taking a leave of absence from her county post to press for passage of Proposition A, a $12.3 million bond issue.

She wants a hospital built in the Watts-Willowbrook area and the voters to give the necessary two-thirds majority at the June 7 primary election to finance such a medical facility.

Dr. Branch sees the hospital as a key step in uplifting the public health in Watts, and other sections.

But, she is apprehensive.

"People, even well-educated people, don't seem to understand many health problems," she declared adding:

"They don't seem to realize that disease knows no boundaries."

Diptheria

She cited one case of a Watts woman exposed to diptheria who served dinner to 30 persons in Beverly Hills.

Dr. Branch gives many reasons why she feels a hospital in her area would improve health conditions, including:

1 — Make access to treatment more convenient for local persons, many of whom depend solely on limited public transportation.

2 — Enable doctors to have closer contact with their patients for continuity of care so that problems can be analyzed and preparations made for possible emergencies.

3 — Attract more and better qualified physicians. Currently there are only 65 doctors serving 150,000 residents in the area.

4 — Help provide jobs for some residents and elevate their standard of living to a more wholesome level.

Dr. Branch laments the high infant and maternal mortality in her health area, as compared with the average throughout the county.

In her district, which contains Watts, the infant mortality is 31.5 per 1,000 live births, compared with 23 deaths per 1,000 county-wide.

The maternal death rate is nearly three times the county-wide rate, with 8.9 mothers dying per 10,000 safe births.

The county-wide average is 3.5 deaths per 10,000 births.

The proposed Watts hospital service area contains 17 per cent of the population throughout the county, yet a much larger percentage of most diseases.

Tuberculosis is 28.4 per cent; hepatitis, 25.2; meningitis, 22.8; measles, 25.8; typhoid fever, 26.3; food poisoning, 42.2, and venereal disease, 46.1.

Dr. Branch blames much of the high incidence on crowded living conditions, often brought on by the influx of southerners to live with relatives in Watts.

She said the area has 14,000 people per square mile, and that sometimes as many as 8 to 10 children live within two rooms.

Copley News Service Photo

HEALTH BLIGHT ON LOS ANGELES
County Supervisor Kenneth Hahn and Dr. Geraldine Branch, Watts district health officer, point to biggest "health gap" in county.

Child, 3, Drowns—

(Continued from Page 1-A)

pool filtering device. After starting the filter, she left the pool area, wrapped a small chain around the gate but said she apparently failed to lock the chain as she usually does.

Mrs. Edwards said about 5 p.m. she left her home to go shopping.

Fifteen minutes later, she returned home and went to the pool to turn the filter off. She said at that time both gates were closed.

As she approached the pool's edge, she found the small girl's body lying partially submerged, face-up, in the water.

"I thought someone was playing a prank at first," she said. "It looked like a large doll."

At that moment the dead child's mother, Laurine Stokes, 30, ran into the pool area and saw her daughter's body.

Mrs. Stokes said she hadn't missed her daughter until about 5:05 p.m. At that time she began searching the neighborhood to eventually find her in the Edward's pool.

An unidentified neighbor called sheriff's deputies. The limp body was taken to San Gabriel Community Hospital around 5:35 p.m.

What was it like for most people to travel to Los Angeles County-USC for healthcare?

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Excluded from the area's private hospitals, poor Black residents were forced to travel to Los Angeles County General Hospital, which, by bus, was two hours each way. When residents reached the hospital, they were also often subjected to care that was dehumanizing and of poor quality.

As this article shows, however, many middle class Black residents (such as those living in Compton at the time), saw the need for a County Hospital as a race issue which required them to put aside their status as tax payers.

Figure 4.4 Drew Medical Society 1971 Membership Map

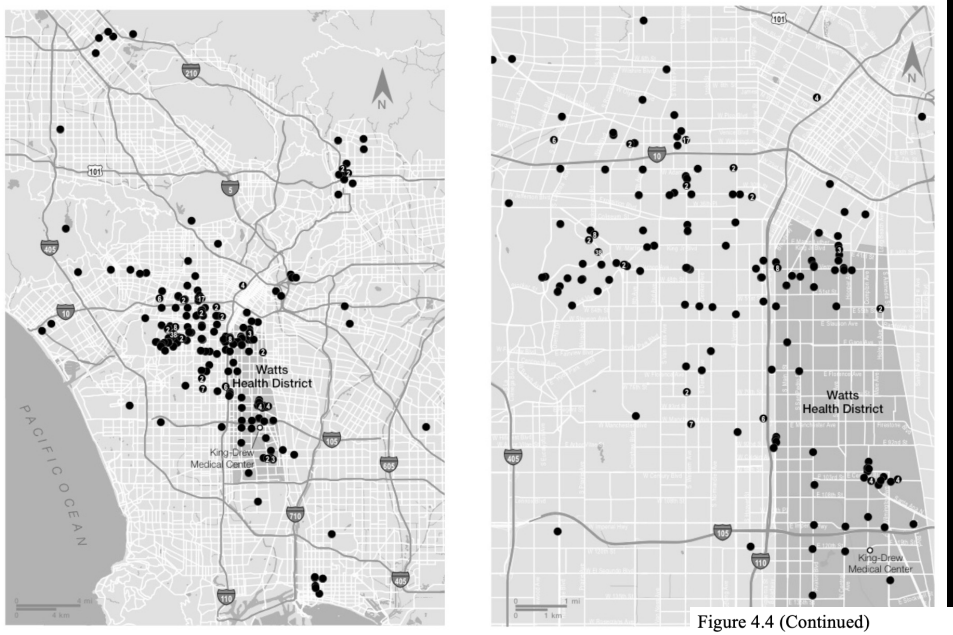


Figure 4.4 (Continued)

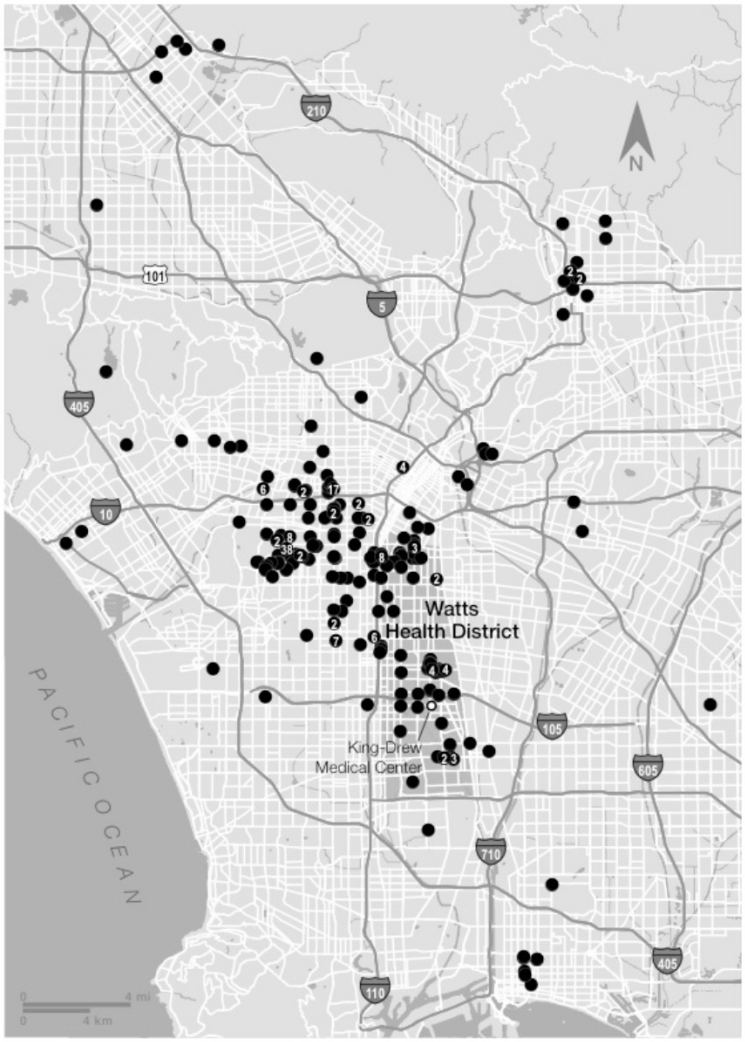
The Drew Medical Society provided a roster of all members in 1971 that reflected each member's self-identified specialty/specialties and whether or not they were board certified or board eligible as of 1968. With a total of 316 members, a majority of members resided in Los Angeles but members provided addresses in Orange County, Ventura, Riverside, and San Bernardino. Each black point represents a single stand alone practice, a black dot with a number within it represents a group practice; the number representing how many in that location. The left map provides an expanded view of the county while the right provides a more detailed map of the original Watts Health District. Approximately 68 (21%) physicians out of 316 practice within the original King Health District Boundaries.

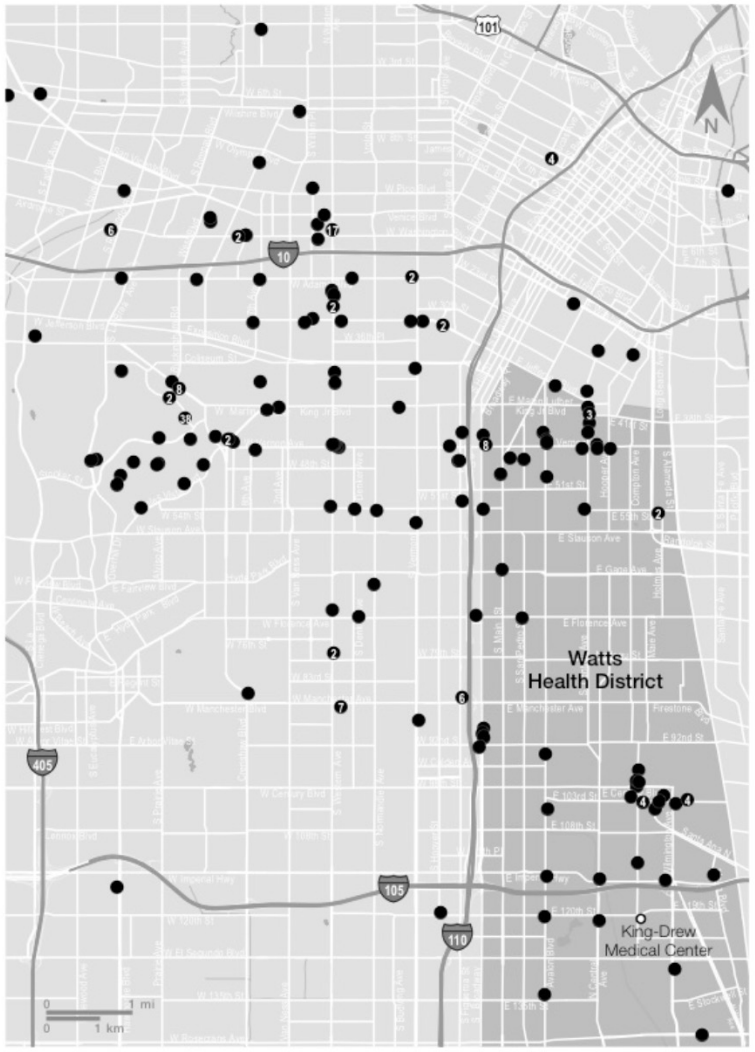
Self-Identified Specialty	*Total*	*Certified*	*Eligible*	*Self-Identified Specialty*	*Total*	*Certified*	*Eligible*
ADM - Administration	2	--	--	NS - Neurosurgery	1	--	--
AM – (Unknown)	1	1	--	OBG – Obstetrics & Gynecology	35	8	8
ANES – Anesthesiology	8	2	1	OO - Retired	5	--	1
CEG – (Unknown)	2	--	--	OPH – Ophthalmology	3	2	--
D - Dermatology	3	1	1	OPH-OTO – Opth/Otolaryngology	3	--	1
GP – General Practitioner	100	1	1	ORS – Orthopedic Surgery	5	1	--
GP-GS - Gen. Practice/Gen. Surgery	2	--	--	P - Psychiatry	15	6	3
GP-OBG - Gen. Ob. & Gynecology	1	--	--	P-CHP – Child Psychiatry	3	1	1
GP-PD - Gen. Pediatrics	1	--	--	PATH - Pathology	2	--	--
GP-PUD – Gen. Pulmonary Disease	1	--	--	PD - Pediatrics	21	6	2
GS – General Surgery	31	13	3	PD-PDA – Pediatric Allergy	3	3	--
GS-TS- General Thoracic Surgery	1	1	--	PD-PDC – Pediatric Cardiology	2	2	--
GS-VS – General Surgery (Unknown)	2	2	--	PH – Public Health	4	--	--
IM – Internal Medicine	34	4	4	Podiatrist - Podiatry	1	--	--
IM-CD - Int. Med. Cardio. Disease	7	2	1	R - Radiology	7	1	--
IM-GE – Int. Med Gastroenterology	1	1	--	TS – Thoracic Surgery	1	1	--
N - Neurology	1	1	--	U - Urology	7	2	2

Total: 316 Total Board Certified: 62 Total Board Eligible: 29

Source: Drew Medical Society Roster 1971. Kenneth Hahn Collection, Box 205, Folder 64 Health Services (Special Collections, Huntington Library)

Figure 4.4 Drew Medical Society 1971 Membership Map





What does this map say about the relationship of Black doctoring to Black poverty?

Most Black physicians were just as allergic to Black poverty as White physicians and hospital owners. The most successful Black physicians cultivated private practices or private group practices in “integrated neighborhoods” where a quarter of the population was Black and middle-class.

Practicing in integrated neighborhoods allowed Black physicians to match the risings standards of physician practice associated with white physicians, but it drew them further and further away from the Black community to do so. This is particularly true for Black physicians with specializations, because training as a specialist frequently meant that they were training and practicing in neighborhoods with few people of color.

On the same token, Black physicians who practiced in solidly Black neighborhoods were often asked to serve double-duty as community leaders. Their location in Black neighborhoods, however, also cast suspicion on their training and skills because it prompted other physicians to see their location as proof of inferior training and expertise. If a doctor could make more money, why wouldn’t he?

Problems Facing the Negro in Medicine Today

M. Alfred Haynes, MD

The black physician faces a real dilemma. If he establishes practice in the suburbs he obviously lacks social consciousness and many of his white colleagues will wonder why so few black physicians practice in the ghetto. If he practices in the ghetto, they will assume that he is incompetent, for why would a dedicated, competent physician practice in the ghetto? If he practices in the ghetto, he may have to see more patients than optimal because there are so few physicians there. As a result, he will be charged with practicing poor quality medicine. If he does not see the patients he will be ill spoken of by the community. If he has a busy practice, he may do well financially but this will be interpreted as gouging the poor patients. If he does not do well financially, he obviously is not a good doctor. In fact, the only way to become an ideal physician is to become a university critic and do nothing about the real problems of community medicine.

Figure 4.4 (Continued)

The Drew Medical Society provided a roster of all members in 1971 that reflected each member's self-identified specialty/specialties and whether or not they were board certified or board eligible as of 1968. With a total of 316 members, a majority of members resided in Los Angeles but members provided addresses in Orange County, Ventura, Riverside, and San Bernardino. Each black point represents a single stand alone practice, a black dot with a number within it represents a group practice; the number representing how many in that location. The left map provides an expanded view of the county while the right provides a more detailed map of the original Watts Health District. Approximately 68 (21%) physicians out of 316 practice within the original King Health District Boundaries.

Self-Identified Specialty	*Total*	*Certified*	*Eligible*	*Self-Identified Specialty*	*Total*	*Certified*	*Eligible*
ADM - Administration	2	--	--	NS - Neurosurgery	1	--	--
AM – (Unknown)	1	1	--	OBG – Obstetrics & Gynecology	35	8	8
ANES – Anesthesiology	8	2	1	OO - Retired	5	--	1
CEG – (Unknown)	2	--	--	OPH – Ophthalmology	3	2	--
D - Dermatology	3	1	1	OPH-OTO – Opth/Otolaryngology	3	--	1
GP – General Practitioner	100	1	1	ORS – Orthopedic Surgery	5	1	--
GP-GS - Gen. Practice/Gen. Surgery	2	--	--	P - Psychiatry	15	6	3
GP-OBG - Gen. Ob. & Gynecology	1	--	--	P-CHP – Child Psychiatry	3	1	1
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Total: 316 Total Board Certified: 62 Total Board Eligible: 29

Source: Drew Medical Society Roster 1971. Kenneth Hahn Collection, Box 205, Folder 64 Health Services (Special Collections, Huntington Library)

Are there any patterns related to certification and board eligibility? Any patterns related to specialties related with postgraduate fellowships (sub-specializations)?

For many, maintaining certifications and board eligibility felt un-necessary because not having them did not preclude them from making money and finding willing patients. More importantly, certification and board eligibility meant very little given that the career advancements associated with them appeared to be out of reach because of the widespread career discrimination found in medicine.

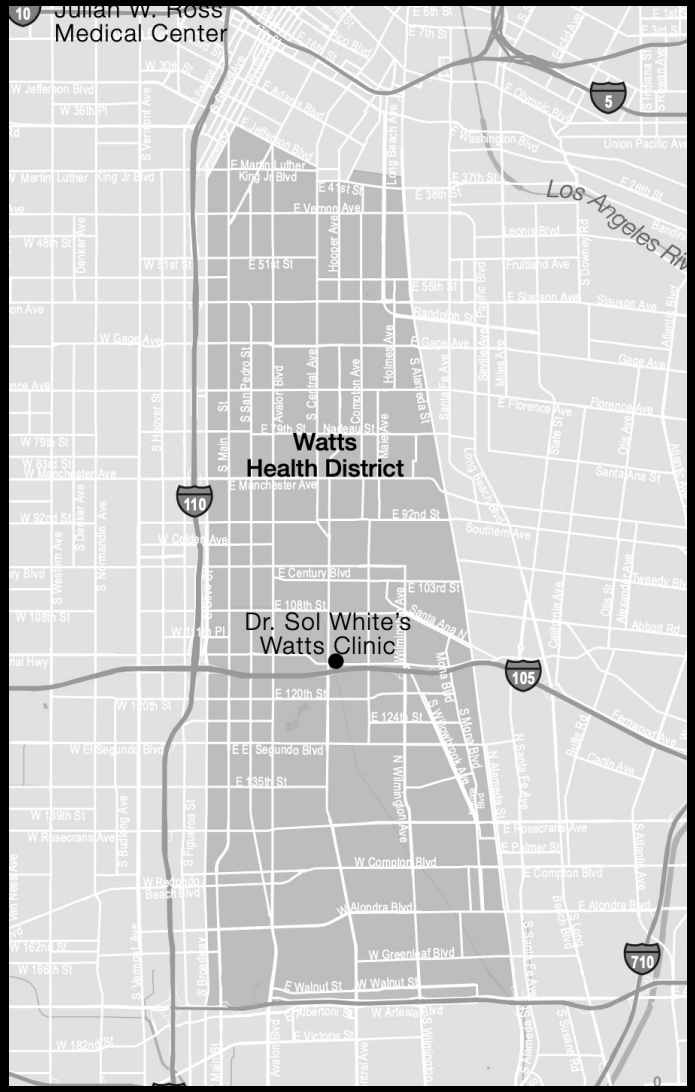
Problems Facing the Negro in Medicine Today

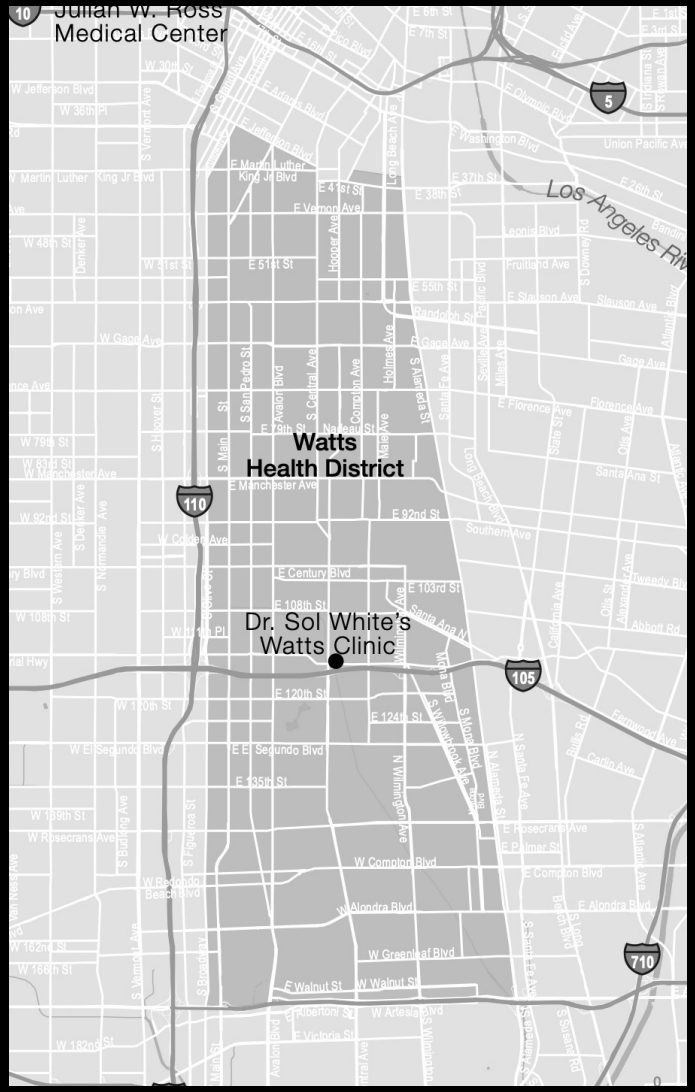
M. Alfred Haynes, MD

The Physician in Practice

When the black physician begins practice his problems do not end. He may have little difficulty establishing an office, but he may find difficulty obtaining hospital privileges even though he may be board certified. Here the hospitals use a similar discriminatory tactic as the academic institutions. The great barrier is "competence." It is a great misfortune not only for black physicians, but for the American people that hospitals do not at present have a satisfactory, objective method of determining competence. As a result, some hospital boards still exclude black physicians more on the basis of race than on competence. Black physicians would have no reasonable objection if the same standards were objectively applied to all. Consumers are rightly confused when a physician is considered competent to practice in one hospital but not in another. If a physician is certified by his specialty board or by the American Academy of General Practice, he should be assumed competent to practice in any hospital. This should include university hospitals, some of which are now the exclusive domain of faculty members. Only too often, the black physician is assumed to be incompetent until it can be rigorously proved otherwise, when in fact, it should be just the opposite.

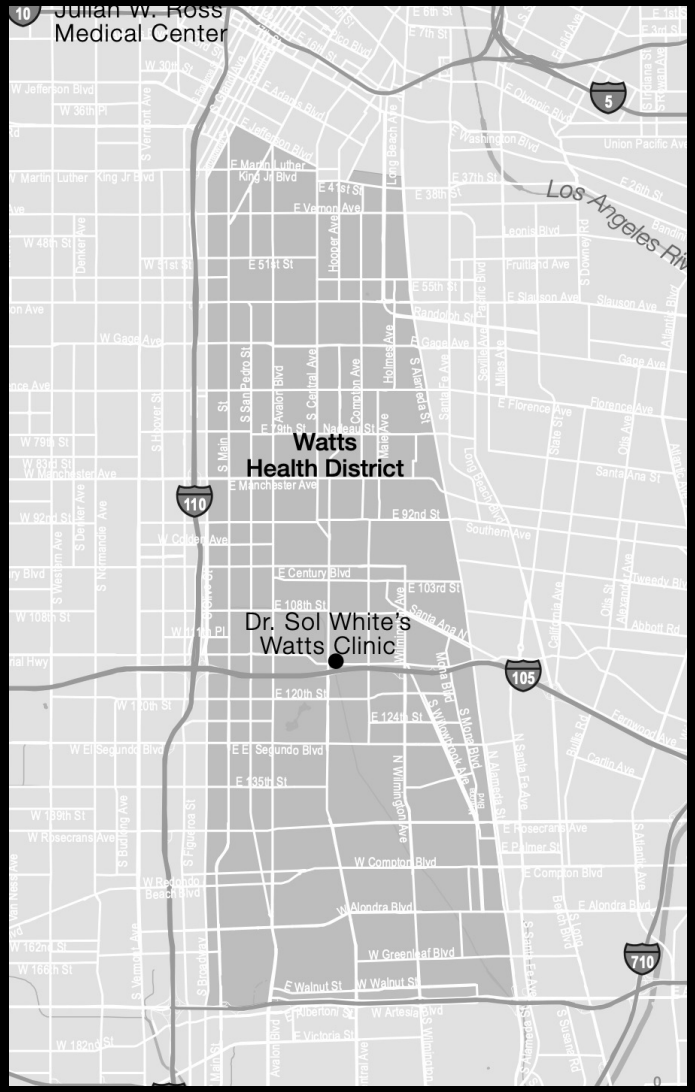
These data points reveal two unsettling points regarding race relations in the 1960s:





These data points reveal two unsettling points regarding race relations in the 1960s:

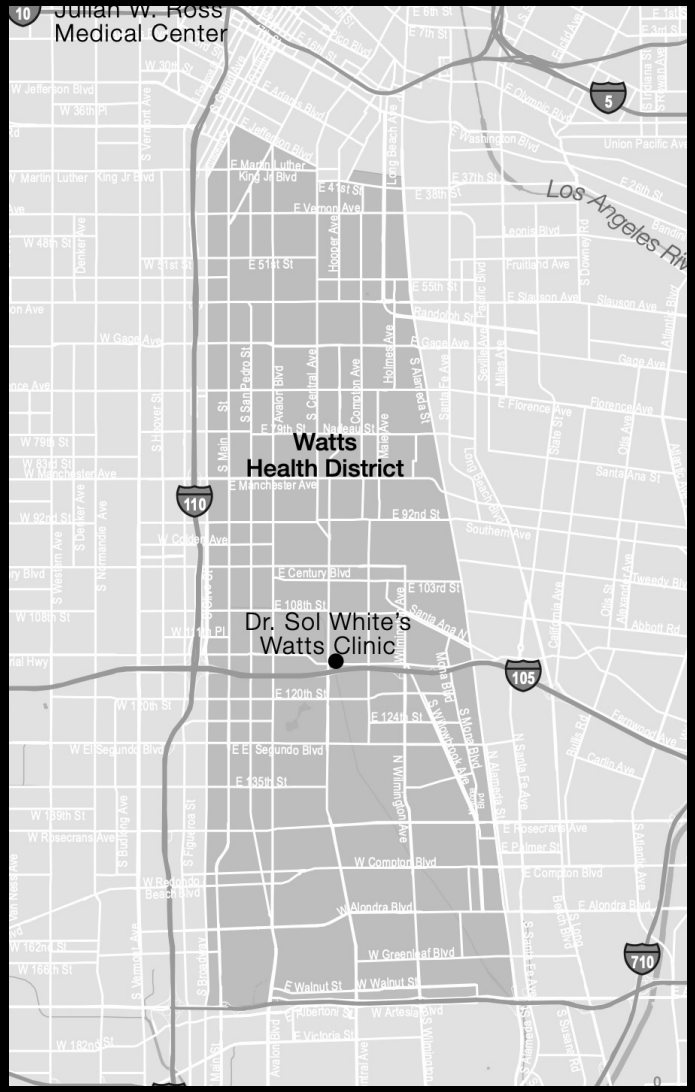
First, it shows the complete abandonment of white capital and resources in neighborhoods of color after WWII.



These data points reveal two unsettling points regarding race relations in the 1960s:

First, it shows the complete abandonment of white capital and resources in neighborhoods of color after WWII.

Second, it shows that Black physicians and other Black middle-class residents had partially contributed to this abandonment of capital and resources by locating their homes and businesses outside of core Black neighborhoods.



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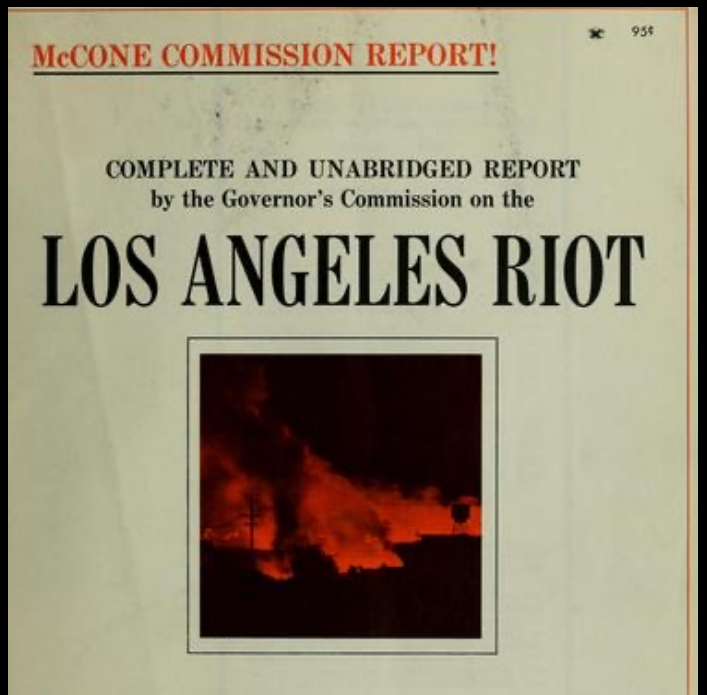
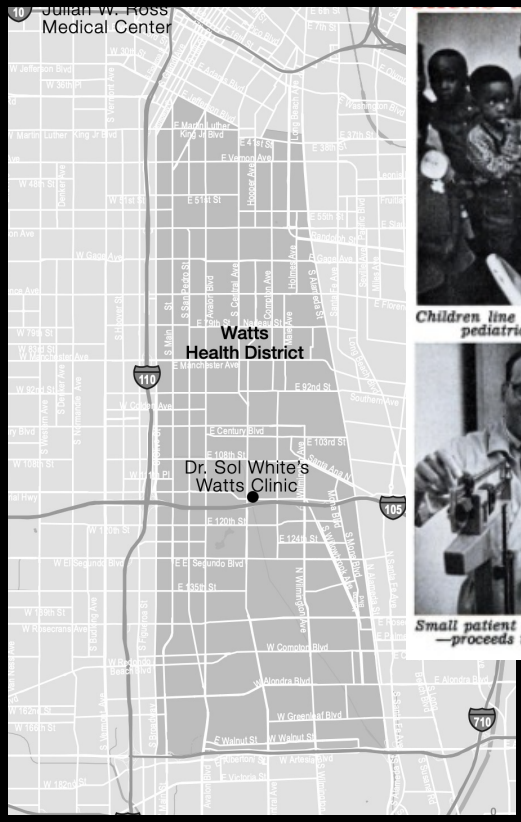


Many Black physicians, such as Dr. Sol White, saw the Watts Uprisings and new federal health and anti-poverty funds as occasions to rally Black physicians to re-commit themselves to the development of Black neighborhoods and healthcare.

“Most of the other medical men – with an eye toward wealthier customers and owning mansions – aimed toward a more middle-class market – preferably integrated”

“Considering himself a Watts’ social worker-oriented physician, Dr. White strongly believes that Negro leadership must embrace segregation ‘for awhile’ to solve problems in the ghettos.”

Across street from his office, Dr. White stands on spot where store formerly stood before fiery Watts riots last year.



Children line his office and await turn for checkup as affable pediatrician checks boy's ear for possible infection.

Small patient doesn't care too much for physician's stethoscope —proceeds to loudly voice his displeasure. Doc weighs boy.

A SCHOOL WITHOUT WALLS
NO BARRIERS AT ALL TO
ACCESSIBILITY
A SCHOOL WITHOUT WALLS;
A PART AND PARCEL OF THE
VERY FABRIC OF THE
COMMUNITY.
RESPONSIVE AND RESPONSIBLE.
RESPONSIVE TO
NEED AND PASSION.
RESPONSIBLE FOR ITS ACTIONS.
COMMITTED TO COMMUNITY;
ITS GROWTH AND ORDER
OPEN AND FREE
A SCHOOL WITHOUT WALLS.

A NEW SETTING FOR COMMUNITY MEDICINE

MLK·DREW

If ”Modern” Medicine =

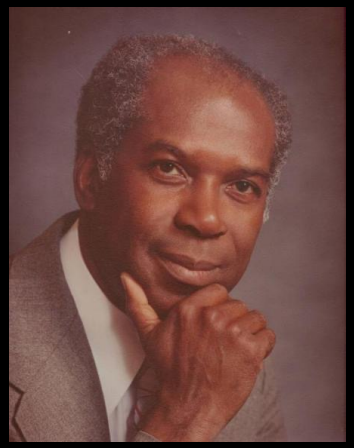
Free Market Capitalism
Heteronormative Patriarchy
Emphasis on Biomedicine

Then Racial Equality =

Free Market Capitalism
Heteronormative Patriarchy
Emphasis on Biomedicine

Problems Facing the Negro in Medicine Today

M. Alfred Haynes, MD



Far from abolishing the National Medical Association, black physicians invite all physicians to join them in removing the barriers between government medicine and private medicine; in once and for all abolishing charity medicine; in bringing the poor into the mainstream of American medicine; and in helping every American, black or white, rich or poor, to enjoy the benefits of adequate health care.

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Problems Facing the Negro in Medicine Today

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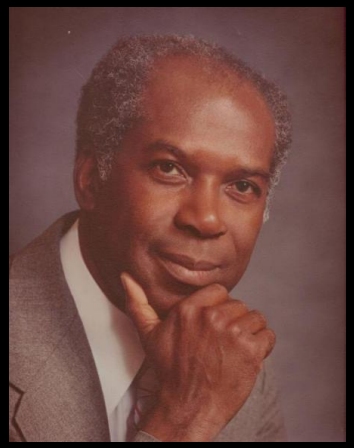

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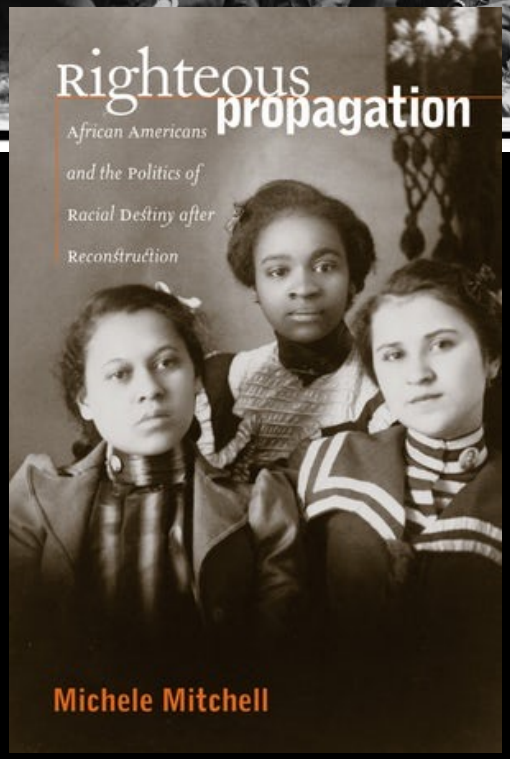
This meant that Black physicians organized in the National Medical Association valorized for-profit healthcare as “mainstream,” saw universal healthcare as a threat to Black physician advancement, and saw women in the profession as curious and unnatural.



By the 1900s, African American leaders, both elite and working class, developed a shared politics of respectability which aligned Black cultural practices to mainstream white gender and sexual values

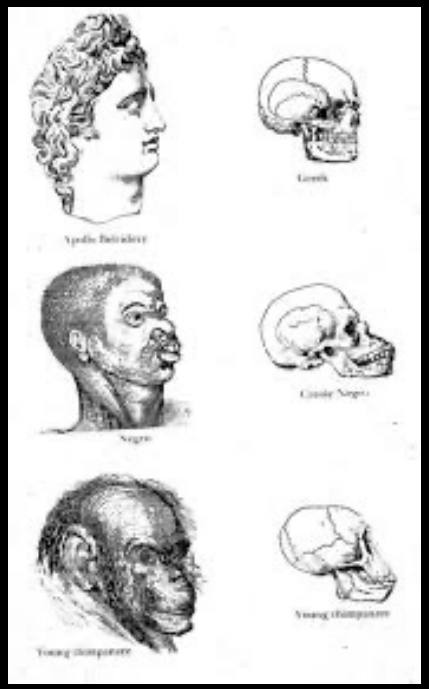
WEB DuBois
Talented Tenth

“The Negro Race, like all races, is going to be saved by its exceptional men. The problem of education, then, among Negroes must first of all deal with the Talented Tenth; it is the problem of developing the Best of this race that they may guide the Mass away from the contamination of death of the Worst.”

Booker T. Washington
Cast Down Your Bucket Where You Are

“To those of my race who depend on bettering their condition… I would say, ‘Cast down your bucket where you are’ – cast it down… in agriculture, mechanics, in commerce, in domestic service, and in the professions… No race can prosper until it learns that there is as much dignity in tilling a field as in writing a poem.”

These Black cultural practices contested the belief that African Americans were inherently promiscuous, immoral, and dependent on white patronage. They also believed such practices and values were necessary in surviving the race, both in terms of biological reproduction and in the social reproduction of community.



Two Problems

”Low” Standards of Doctoring

”Low” Income of Black Laborers

Two Problems

”Low” Standards of Doctoring

”Low” Income of Black Laborers

After Watts Uprisings in 1965, the City and County of Los Angeles, USC Medical School, UCLA Medical School, and Drew Medical Society (NMA) create

King-Drew Medical Center
MLK Hospital + Drew Medical School

Two Problems

”Low” Standards of Doctoring	”Low” Income of Black Laborers
Produce New Doctors	
Rehabilitate the Skills and Expertise of Existing Doctors	

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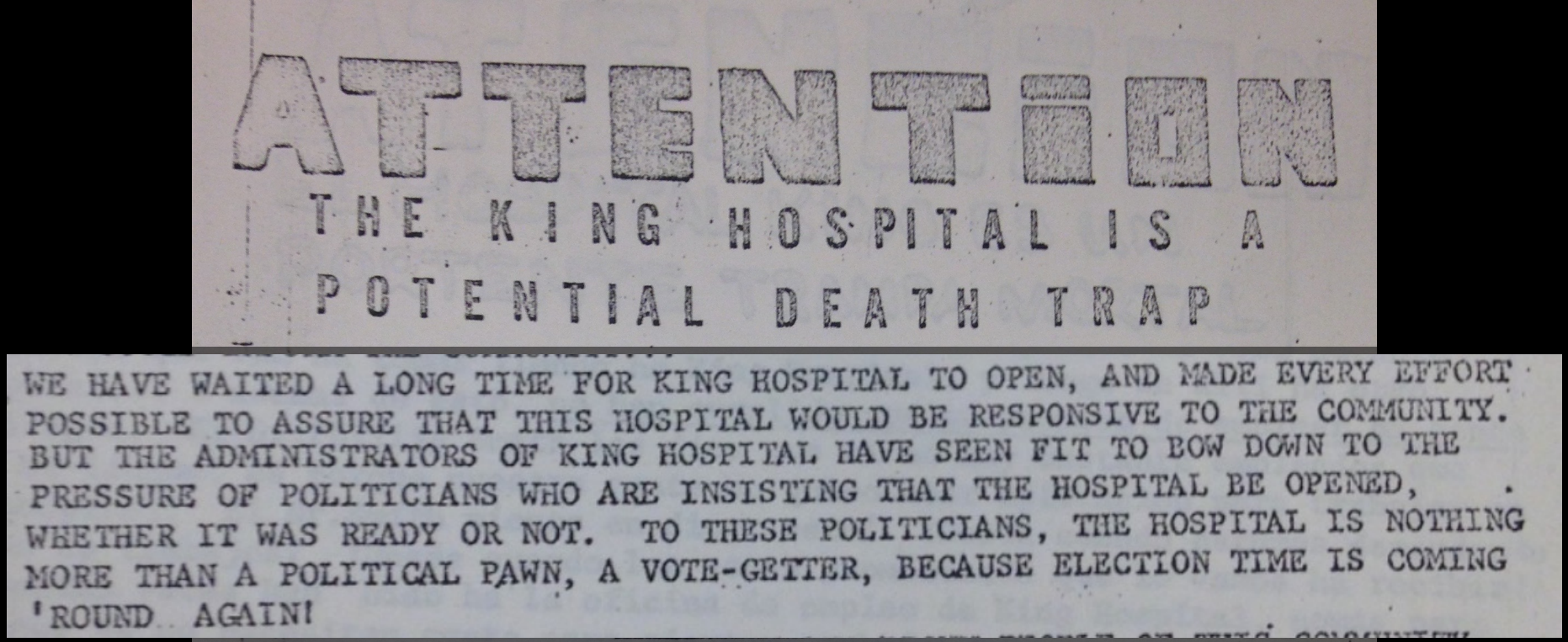
”Low” Standards of Doctoring	”Low” Income of Black Laborers
Produce New Doctors Rehabilitate the Skills and Expertise of Existing Doctors	Employ and train Black men to maximize their status as breadwinners

= Match the consumer power of white male breadwinners and the expertise and talent of white male specialists

Anesthesiology	Ob/Gynecology
Internal Med	Pathology
Pediatrics	Radiology
Psychiatry	Surgery

The focus on producing highly talented and highly skilled physicians, however, forced King-Drew's leaders to recruit physicians who were neither from Los Angeles and were, in some cases, not Black.



ATTENTION

THE KING HOSPITAL IS A POTENTIAL DEATH TRAP

WE HAVE WAITED A LONG TIME FOR KING HOSPITAL TO OPEN, AND MADE EVERY EFFORT POSSIBLE TO ASSURE THAT THIS HOSPITAL WOULD BE RESPONSIVE TO THE COMMUNITY. BUT THE ADMINISTRATORS OF KING HOSPITAL HAVE SEEN FIT TO BOW DOWN TO THE PRESSURE OF POLITICIANS WHO ARE INSISTING THAT THE HOSPITAL BE OPENED, WHETHER IT WAS READY OR NOT. TO THESE POLITICIANS, THE HOSPITAL IS NOTHING MORE THAN A POLITICAL PAWN, A VOTE-GETTER, BECAUSE ELECTION TIME IS COMING 'ROUND AGAIN!

FORTUNATELY FOR US, THERE ARE SOME DEDICATED PEOPLE ON THE STAFF OF KING HOSPITAL, WHOSE NAMES CANNOT BE MENTIONED HERE, FOR OBVIOUS REASONS, WHO

'ROUND AGAIN!

AND ONCE MORE, THE NEEDS OF THE BLACK AND BROWN PEOPLE OF THIS COMMUNITY, WHOSE TAX MONEY SUPPORTED THE COST OF BUILDING THIS HOSPITAL, ARE BEING DISREGARDED!! ONCE MORE WE ARE BEING ASKED TO ACCEPT SECOND-RATE SERVICES!!

WE ARE ASKING ALL THE MEMBERS OF THIS COMMUNITY TO JOIN WITH US IN OUR PROTEST AGAINST THE FARCE THAT IS BEING PLAYED BY THE ADMINISTRATORS OF KING HOSPITAL....

REMEMBER THAT THE LIVES THAT THEY ARE PLAYING WITH ARE YOURS, MINE , NOT THEIRS!

"Early in Drew's planning, the board of directors decided that senior faculty would be recruited on a nationwide basis rather than solely from the medical community of South-Central Los Angeles. This decision has had repercussions that can still be felt and that have had both positive and negative impacts on Drew's growth." – King-Drew Master Plan Study

Jobs First, Women and Children Second

High-cost hospital services only accessible through clinic referral and only if a resident of catchment zone

Neighborhood Health Clinics

High Cost Public Hospital Services

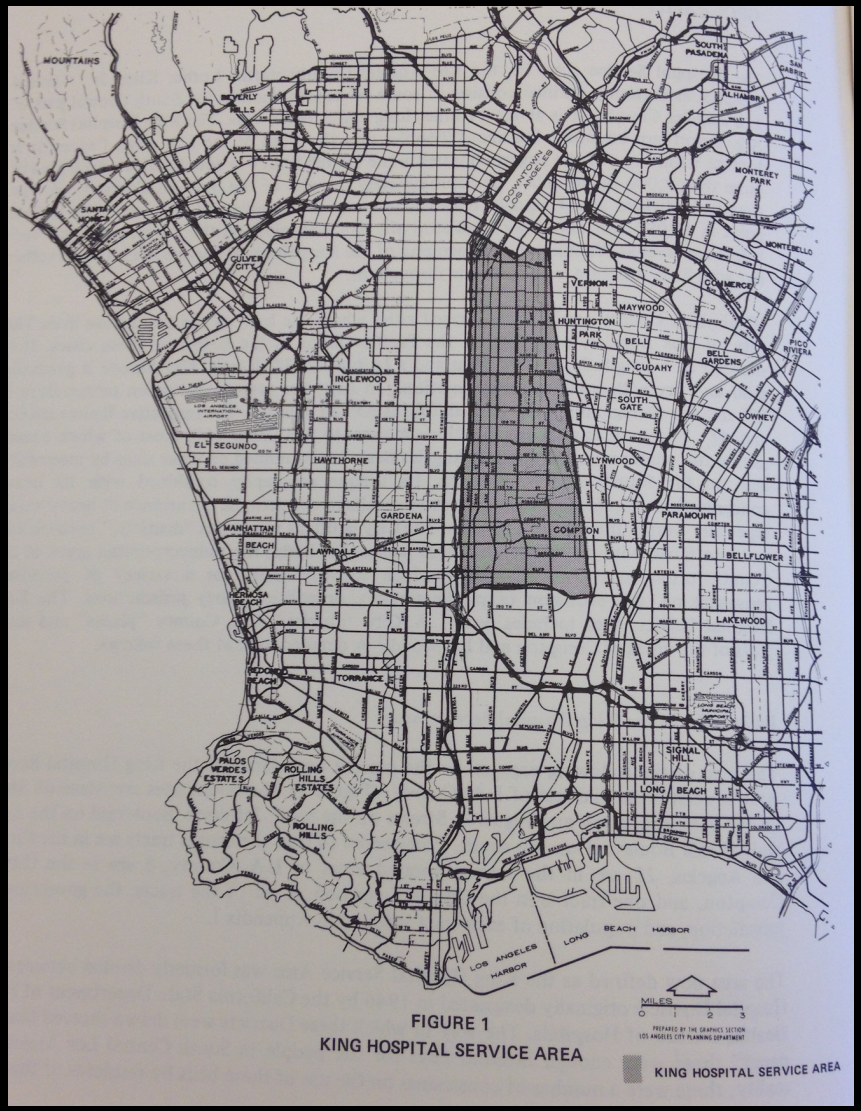


FIGURE 1
KING HOSPITAL SERVICE AREA

ATTENTION

THE KING HOSPITAL IS A

POTENTIAL DEATH TRAP

ON THURSDAY, MARCH 23rd, DR. PHILLIP SMITH TOLD MEMBERS OF THE COMMUNITY THAT THE HOSPITAL WAS READY TO OPEN, INCLUDING THE EMERGENCY SERVICES, WHICH HE DESCRIBED AS FULLY EQUIPPED AND ADEQUATELY STAFFED WITH PERSONNEL WHICH INCLUDED BI-LINGUAL EMPLOYEES.....

COMMUNITY STATING THAT SERVICES WERE LIMITED, AND THAT THEY WERE NOT ACCEPT-

IS NOT READY TO OPEN!

FORTUNATELY FOR US, THERE ARE SOME DEDICATED PEOPLE ON THE STAFF OF KING HOSPITAL, WHOSE NAMES CANNOT BE MENTIONED HERE, FOR OBVIOUS REASONS, WHO

"There are innumerable problems still to be worked out, not the least of which is the relationship with the Watts community. It is organized, has some militant leadership and is determined to have a role in the development of the health care system." – King-Drew Master Plan Study

Doctors Fear King Hospital May Become Charity-Oriented

But Official Assures Group of Black Medical Men That Operation Will Provide Health Care for Total Community

BY STANLEY O. WILLIFORD
Times Staff Writer

The most visible and imposing monument to rise out of the ruins left by the Watts riot is the Martin Luther King Jr. General Hospital.

Blacks now hold about 43% of the construction jobs at the site, and later are expected to fill some 1,500 to 2,000 more jobs the hospital will generate.

The hospital could also be of benefit to the black doctors in South-Central Los Angeles, who often charge they are denied admittance to the staffs of the county's larger public and private hospitals. This causes them to suffer the loss of many patients, they claim.

To a man, the county's 465 black doctors can belong to the staff of the King Hospital.

It would seem that an institution which would fulfill so many of the community's needs—mainly those of good health and jobs—would be unopposed.

But a group of black doctors has heatedly criticized the way the hospital will be run. There has even been talk of blocking construction.

Others believe the King Hospital is one of the grandest schemes in medicine.

When the hospital opens in the spring of 1971, it will be staffed by the Charles R. Drew Postgraduate Medical School, an organization of black doctors mainly active in South Los Angeles, and by interns and residents from both USC and UCLA medical schools.

Built on a 40-acre site at 120th St. and Wilmington Ave. in Willow-

Racial Capitalisms

Structure of White Supremacy & Medicine

White Physicians

White Workers

Black Physicians

Black Workers

Black people, although no longer bonded in slavery, were still a fungible property of whiteness based on their relationship to labor and healthcare

"Black Capitalism" / Multi-cultural Capitalism

White Physicians

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Re-channel Black labor and sickness to Black doctors

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Either way, the examples I have drawn from today should show you that poor Black people and poor people of color have been and are central to the operation of for-profit healthcare. They show you that the labor and sickness of poor neighborhoods of color make possible medical education, particularly postgraduate medical education, and that their spatial entrapment through residential segregation is a key element in maximizing profit and medical innovation in neighborhoods outside them.