ENTERING A WHITE PROFESSION: BLACK PHYSICIANS IN THE NEW SOUTH, 1880–1920

Todd L. Savitt

In the late 1890s a young Kentucky physician wrote optimistically to his black sociologist W. E. B. DuBois:

I am located in a town of 12,000 inhabitants, one-third of whom are colored, and am thoroughly convinced that there is a great field here in the South for the educated colored man. As a physician I am well received by my white professional brethren. We ride in the same buggies, consult together, and read each other’s books. I have a few white patients, but most of them are colored. I have purchased property on one of our best residence streets and also a business house on the main street of our town.

A few years later, a national monthly medical journal sandwiched between correspondence on treatments for hysteria and the prevention of dog bites the following letter, written, the editor announced, by a Southerner, and printed exactly as received, though without the writer’s name:

 saya ON KEEP NEGRO PHYSICIANS DOWN!

Dr. C. F. Taylor, Ed, of The Med. World.

Dear Sir—What is the negro physician doing as a whole through out the country as a physician and surgeon? What are they doing financially? How do they compare with the white specialists in some examinations through our country? I notice in some places they seem to be making more money than the white physicians. What is the best thing we can do to keep them down? Please let me hear from you in the next No. of the World.

These letters, contradictory in one regard, do agree that black physicians in the highly race-conscious New South were gaining recognition and achieving a measure of success according to the standards of the time. They

*1 Have preserved versions of the paper to the Johns Hopkins University Institute of the History of Medicine. It was a meeting of the American Association for the Study of Race in Medicine, New York, 3-5 June 1996, and the State National Society for the Promotion of Science, September 1996. I gratefully acknowledge the helpful suggestions of participants in both forums and an editorial committee of the University of Carolina. The paper was supported in part by a National Institute of Health grant (A021142) to the National Library of Medicine.


3 Med. World. (1914), 52 (Charles Freeman Taylor, ed.).

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also point to two major concerns of the first generation of post-Civil War black practitioners: reputation and rewards. Like other physicians, black practitioners faced the problems of gaining their patients' confidence and establishing collegial relationships with other local doctors. They had to earn their status among patients and practitioners. Measures of achievement included the number, social standing, financial position, and loyalty of patients; the willingness of already established practitioners to share knowledge, tools, and instruments, and to call or be called for consultation; and, finally, the acquisition of such material displays of wealth as home, office, and rig (horse and buggy) or automobile.

These were important matters to black physicians, but they soon learned, competence, patient acceptance, and material gain were not enough. They also needed to develop group allegiance in order to surmount barriers the local, state, and national white medical profession had erected to keep them out. Black doctors had to build their own parallel professional structures by establishing hospitals, medical societies, pharmacies, medical journals, postgraduate educational institutions, and clinics, as a means of maintaining their standards in medical practice.

In concurrently enhancing their efforts on individual career growth and on improving collegial relations, black physicians of this period subordinated another concern: the overall improvement of black health and health conditions. As black doctors they expected and were expected to improve the health of fellow blacks by providing medical care and by educating the ignorant regarding good health practices. Though it was an important force, one that inspired black physicians of the late nineteenth and early twentieth centuries to enter medicine, this broad ideal of racial betterment did not receive as much attention as other goals once doctors actually entered practice.2

In addition to these concerns, black physicians in the turn-of-the-century South lived with another issue that affected their careers and personal lives—race. For example, they had to overcome black patients' reluctance to use their services; low remuneration from a generally poorer, predominantly black clientele; and an unfriendly reception and professional exclusion from many white physicians. Furthermore, having gained a level of education superior to that of most other blacks, these doctors became representatives of their race to the white world, and community leaders in the black. So they found it difficult to escape pressures of race in their daily lives. The sorts of situations Southern black physicians encountered and the ways they coped with them in their dealings with black patients, white physicians, white patients, and fellow black doctors as they entered the previously white medical profession are the subjects of this paper.

As Table 1 indicates, the number of black physicians in the United States increased dramatically between 1890 and 1920 as medical schools devoted to educating blacks opened their doors.4 Most graduates remained in the South, where they had grown up and learned medicine (there were no black medical schools in the North), but as the rest of the black population began to migrate northward in the early decades of the twentieth century, so did black physicians. Though their ranks grew in all parts of the country, black doctors generally constituted only a tiny proportion of the medical profession between 1890 and 1920. Similarly, the ratio of black citizens to black doctors in each state and in the nation as a whole increased greatly during that time period, but, with a few exceptions in cities with black medical schools, remained much poorer than for whites (see table 2).

Most black physicians in practice before 1920 had attended one of the dozen missionary or proprietary medical schools established in the South for former slaves after emancipation (see table 3). Through every phase of their educational careers, beginning with the reading of medical college catalogs and ending with commencement addresses at degree-granting ceremonies, black medical students learned how black people needed them, how they could help raise up the race, and how personally rewarding the profession of medicine was. Never did they hear complaints—increasingly common in the white medical community before 1920—about an overcrowded medical field.5 Black physicians were in demand.


4 New Orleans University, Department of Medicine and Surgery, Catalogue of 1875–96, p. 4. Similar pronouncements may be found in catalogs of the other black medical schools.


Table 2. Black and White Physicians in Southern States and Selected Southern and Northern Cities, 1890 and 1920

<table>
<thead>
<tr>
<th>Location</th>
<th>1890 */1920</th>
<th>Change in Rate (%)</th>
<th>1980 */1920</th>
<th>Change in Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Black Physicians</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>8,403.41</td>
<td>2,994.1</td>
<td>-64.3</td>
<td>531.7</td>
</tr>
<tr>
<td>Southern states</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alabama</td>
<td>24,232</td>
<td>8,479</td>
<td>-64.9</td>
<td>464.0</td>
</tr>
<tr>
<td>Arkansas</td>
<td>7,728</td>
<td>3,148</td>
<td>-59.5</td>
<td>368.9</td>
</tr>
<tr>
<td>Delaware</td>
<td>14,195</td>
<td>4,324</td>
<td>-69.0</td>
<td>556.7</td>
</tr>
<tr>
<td>Florida</td>
<td>13,868</td>
<td>2,728</td>
<td>-79.4</td>
<td>403.5</td>
</tr>
<tr>
<td>Georgia</td>
<td>21,470</td>
<td>5,391</td>
<td>-72.5</td>
<td>458.9</td>
</tr>
<tr>
<td>Kentucky</td>
<td>6,383</td>
<td>1,322</td>
<td>-78.2</td>
<td>278.2</td>
</tr>
<tr>
<td>Louisiana</td>
<td>13,736</td>
<td>7,103</td>
<td>-49.6</td>
<td>603.2</td>
</tr>
<tr>
<td>Maryland</td>
<td>5,829</td>
<td>3,708</td>
<td>-36.5</td>
<td>487.9</td>
</tr>
<tr>
<td>Mississippi</td>
<td>23,860</td>
<td>14,149</td>
<td>-41.1</td>
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</tr>
<tr>
<td>Missouri</td>
<td>5,564</td>
<td>893</td>
<td>-83.4</td>
<td>944.8</td>
</tr>
<tr>
<td>North Carolina</td>
<td>12,196</td>
<td>6,347</td>
<td>-46.9</td>
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<tr>
<td>Oklahoma</td>
<td>5,158</td>
<td>3,257</td>
<td>-36.6</td>
<td>395.2</td>
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<tr>
<td>South Carolina</td>
<td>22,964</td>
<td>10,175</td>
<td>-54.0</td>
<td>630.7</td>
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<tr>
<td>Tennessee</td>
<td>4,282</td>
<td>1,003</td>
<td>-75.6</td>
<td>407.6</td>
</tr>
<tr>
<td>Texas</td>
<td>9,040</td>
<td>3,418</td>
<td>-61.4</td>
<td>480.7</td>
</tr>
<tr>
<td>Virginia</td>
<td>16,253</td>
<td>3,877</td>
<td>-76.3</td>
<td>539.7</td>
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<tr>
<td><strong>White Physicians</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>10,289</td>
<td>9,722</td>
<td>-5.6</td>
<td>974.9</td>
</tr>
<tr>
<td>Southern states</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Alabama</td>
<td>46,931</td>
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<tr>
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<td>950</td>
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</tr>
<tr>
<td>Delaware</td>
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<td>855</td>
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<td>531.6</td>
</tr>
<tr>
<td>Florida</td>
<td>2,009</td>
<td>739</td>
<td>-64.5</td>
<td>259.6</td>
</tr>
<tr>
<td>Georgia</td>
<td>3,063</td>
<td>2,524</td>
<td>-17.3</td>
<td>246.1</td>
</tr>
<tr>
<td>Kentucky</td>
<td>1,224</td>
<td>527</td>
<td>-57.3</td>
<td>570.8</td>
</tr>
<tr>
<td>Louisiana</td>
<td>3,583</td>
<td>2,748</td>
<td>-28.6</td>
<td>478.1</td>
</tr>
<tr>
<td>Maryland</td>
<td>5,598</td>
<td>3,512</td>
<td>-38.3</td>
<td>341.7</td>
</tr>
<tr>
<td>Mississippi</td>
<td>13,035</td>
<td>6,503</td>
<td>-50.5</td>
<td>540.3</td>
</tr>
<tr>
<td>Missouri</td>
<td>8697</td>
<td>846</td>
<td>-2.9</td>
<td>2411.2</td>
</tr>
<tr>
<td>North Carolina</td>
<td>8,173</td>
<td>1,542</td>
<td>-81.1</td>
<td>842.8</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>4,683</td>
<td>1,524</td>
<td>-67.5</td>
<td>1,903</td>
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<tr>
<td>South Carolina</td>
<td>4,557</td>
<td>3,924</td>
<td>-14.1</td>
<td>2,765</td>
</tr>
<tr>
<td>Tennessee</td>
<td>4,282</td>
<td>3,418</td>
<td>-20.5</td>
<td>480.7</td>
</tr>
<tr>
<td>Texas</td>
<td>9,040</td>
<td>3,418</td>
<td>-61.4</td>
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<tr>
<td>Virginia</td>
<td>16,253</td>
<td>3,877</td>
<td>-76.3</td>
<td>539.7</td>
</tr>
</tbody>
</table>

Sources: U.S. Census, 1890 and 1920.

Note: Unless otherwise indicated, figures are for males only. In only a few cases and states did the published census data provide estimates for female physicians by race. In 1890, 8.6 percent of white and 1.7 percent of "colored" physicians were female. In 1920, 7.2 percent of white and 11.5 percent of black physicians were female.

* The occupation listings of the 1890 census grouped blacks, Indians, and persons of Chinese and Japanese descent into one racial category labeled "Colored." (California alone had 286 "colored" physicians, most of whom were from China.) The "colored" physicians in the south were of African descent. ** Includes both males and females. ** The 1890 Census designated "Negroes" and "Colored" in this instance.
student at Leonard Medical School in Raleigh, North Carolina, explained to his classmates in 1886, extended beyond the mere provision of medical care to educating the ignorant about proper health practices. Lawson A. Scruggs, caught up in the excitement of Leonard’s first graduation in 1886, enthusiastically tried his valedictory address “Medical Education as a Factor in the Ellevation of the Colored Race.” Discussing the need of black citizens to hear about recent advances in disease prevention, sanitation, and hygiene, Scruggs asserted, “No one can better teach them these practical and important truths than the educated colored physician who is one of their number.” “The challenges of medicine, he concluded, would spur black physicians to help their fellow citizens “with the same self-sacrifice, courage, and resource as has ever characterized the profession... We who stood before you tonight, are pioneers of the medical profession of our race.”

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Table 3. Black Medical Colleges, 1865–1923

<table>
<thead>
<tr>
<th>City</th>
<th>Year Established</th>
<th>Year Discontinued</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Howard University</td>
<td>1869</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lincoln Medical College</td>
<td>1866</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meharry Medical College</td>
<td>1876</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leonard Medical School of Shaw University</td>
<td>1882</td>
<td>1892</td>
<td>Proprietary</td>
</tr>
<tr>
<td>Louisville Medical College</td>
<td>1886</td>
<td>1922</td>
<td>Proprietary</td>
</tr>
<tr>
<td>Hampton Medical College</td>
<td>1889</td>
<td>1950</td>
<td>Proprietary</td>
</tr>
<tr>
<td>Hite Medical College of New Orleans</td>
<td>1890</td>
<td>1959</td>
<td>Proprietary</td>
</tr>
<tr>
<td>Knoxville College Medical Department</td>
<td>1895</td>
<td>1902</td>
<td>Presbyterian</td>
</tr>
<tr>
<td>Chaminoga National Medical College</td>
<td>1899</td>
<td>1906</td>
<td>Proprietary</td>
</tr>
<tr>
<td>State University Medical Department</td>
<td>1905</td>
<td>1920</td>
<td>Baptist (Ky.)</td>
</tr>
<tr>
<td>Knoxville Medical College</td>
<td>1906</td>
<td>1911</td>
<td>Proprietary</td>
</tr>
<tr>
<td>University of West Tennessee College of Medicine and Surgery</td>
<td>1907</td>
<td>1922</td>
<td>Proprietary</td>
</tr>
<tr>
<td>Medico-Chirurgical and Theological College of Christ's Mission</td>
<td>1908</td>
<td>1910</td>
<td>Proprietary</td>
</tr>
</tbody>
</table>

Black Physicians in the New South

Needed pioneers, as Booker T. Washington told eager Howard University medical students on the opening day of classes in October 1909:

There is great demand for negro doctors. I think we have about 3,500 negro physicians in America. We need at least 7,000 in America. The white doctor has to seek [his] location, then hang out his shingle, but the location seeks the negro doctor. Everybody knows him. So our apparent disadvantages become our advantages."

President Charles F. Meserve of Leonard Medical School had made similar claims in his 1906 commencement address: “This institution and others of similar character cannot begin to meet the calls that are coming constantly for trained physicians and pharmacists.” Letters in his files demonstrated this point. Citizens of one South Carolina town had communicated with Meserve several times over two years and even offered to send a representative to Leonard’s commencement exercises in hopes of convincing one of the young graduates to set up practice there.

Meserve had to inform a citizen of this town that he thought all graduating seniors had “decided upon where they [would] locate.” At black medical schools across the South, prominent residents of large cities like Montgomery, Alabama, and small ones like Hertford, North Carolina, counseled new graduates. Competition was keen to win the services of these young men and women.

For the young black doctor, all of this attention meant instant prestige and status in the black community. As the biographer of the early twentieth-century Memphis physician Joseph E. Walker described the situation in exaggerated terms: In this age and time a Negro doctor was as popular in Negro life as money is in business. With Dr. before a man’s name, he immediately became the community leader, the commanding figure that received the honor, respect and admiration of the entire population. Everybody looked up to him and felt compelled to pay homage to him. Negro men accepted the ideas and thoughts of the colored doctor in all things as right and final, and Negro women worshiped them. In another field it would take time to build up—in medicine it was seemingly an overnight affair. The doctor lived in the best home, wore the best.

1 Armstrong, 1906, p. 3. The issue of Share Women’s newspaper may be found in the North Carolina Collection, Wilson Library, University of North Carolina, Chapel Hill.

2 Armstrong, 1906, p. 3. The issue of Share Women’s newspaper may be found in the North Carolina Collection, Wilson Library, University of North Carolina, Chapel Hill.
clothes, rode the best horse and was the admired suitor of the fairies of the community's fair sex. But instant status did not mean a problem- and struggle-free transition from poor medical student to well-heeled local physician. Black doctors often encountered a disparity between the status accorded them as educated leaders in the community and the level of acceptance given them as professional healers. Just after graduation, however, with applause and words of praise still echoing in their minds, with confidence in their abilities and success on state licensing exams buoying their egos, and with expectations of developing a thriving practice and of helping their people urging them on, newly minted black physicians knew little of these other matters as they set out into the world. Deep within, though, some must have wondered, as did John Edward Perry on his graduation day in Nashville in 1895, "What does the future hold in store?" These black citizens, many just one, two, or three generations removed from bondage, had reached this position because of their drive and determination to succeed. They became some of the first blacks to gain not just literacy or even basic learning, but a higher education and a profession. Their letters of application to medical schools, their correspondence with school authorities about scholarships, summer jobs, and money matters, and the writings of contemporary observers about their situations indicate that few came from "elevated" backgrounds. Most had limited funds and outstanding debt until several years after opening practices. They (and their families) had struggled and sacrificed to get through medical school and continued doing so as they entered medical practice.

Most, then, arrived in their first towns poor, with no horse and buggy or automobile, no office or home, and few material possessions other than some medical books and instruments. They were on their own now to prove themselves capable of earning a living practicing medicine. Community with towns anxious for a physician was over, a letter of reference from former professors were useless. Black physicians now faced the realities of an impoverished patient population, competition with local established white practitioners, and black patients wary, not just of a new physician, but of a black physician. Success was not guaranteed. These new black physicians hopefully hung their shingles outside their rented offices, arranged

Black Physicians in the New South

their medical books on a shelf, readied their few instruments, and waited for patients to call.

It could be a lonely and trying time. A few months after graduating from Leonard Medical School, Dr. William E. Atkins wrote to his former advisor, "I am now in Hampton, Virginia, my future home. I like Hampton very much and consider the outlook very fair but of course it will take time and patience. I can do both if I just don't get too hungry." Another recent Leonard graduate, John H. G. Williams, moved to Columbus, Georgia, in the spring of 1904 and wrote a more confident letter to President Reserve, though financial prospects also dominated his thoughts:

I have arranged about my license and now have my office opened and also have my horse and buggy. I started last Sat. I am... I got my horses (buggy) then. I had my first call Sunday nite and several since. I am getting along nicely to be at an entirely new place. I think my chances are good here, anyway I am satisfied so far.

Frederick Douglas Sessions, Leonard class of 1905, had little spare cash upon his arrival in Henrico, North Carolina, shortly after graduation. The Reverend G.D. Griffin had invited Sessions to practice there well before commencement exercises. The young physician had visited the town, talked to its residents, and decided to settle in Henrico. He used some of his limited funds to rent a one-room office, but he did not have enough extra for a horse. So Sessions visited his local patrons and asked plantation owners to provide him rides to and from their land, and J. Edward Perry recalled years later his actions and feelings shortly after arriving in Mexico, Missouri, in 1895.

With no funds with which to purchase office equipment or the payment for [office] space, the idea suggested itself to begin practice from my residence [rented room]. A sign was secured and nailed against the outside wall, cards were printed and I was ready for the first call... There were only three lonely days before a request was made for me to see a patient... [That first Sunday] a shadow of gloom hovered over me as I thought of friends, mother and father far away, while I struggled among strangers.

Under such circumstances, pursuit of humanitarian ideals of racial health improvement and patient education must have seemed remote and easy to postpone.

Sometimes the local church provided comfort for lonely black physicians in new towns, and also some needed publicity to help start a practice. Upon arriving in Frankfort, Kentucky, for example, Edward Ellsworth Underwood, an 1891 graduate of Western Reserve Medical School, received

15 John Edward Perry, Perry's Graduates of Medical Schools in the United States and Canada (Chicago: American Medical Association, 1896), p. 124. The proper information on Dr. Perry, as important Tennessee physician, see Martin Howard, Steam Gaffney and Todd L. Smith, eds., Dictionary of American Medical Biography, 3 vols. (Blue Ridge Summit, 1993), 2:152.
16 On older, see, for example, Cancer Bulletin in Medicine, 1 September 1905, Letter 5-1, William A. Haggard to Medicine, 31 December 1905, Letter 10-2, Jerusalem H. Driscoll to Medicine, 25 November 1899, Letter 2-1, and John W. Jones to Medicine, 1 April 1899, Medicine Letter, 5, p. 462, all in New Archives, Williamson, Struggling to Cope, p. 55; Christian Education, 1899-91, p. 396.
17 See, for example, Medicine in Texas: A Medical History, 4 May 1929, Medicine Letterbook 1, p. 495, Shaw Archives.
18 Addins to Medicine, 8 October 1896, Letter 1-1, Shaw Archives.
19 Williamson to Medicine, 12 May 1903, Letter 2-1, Shaw Archives.
20 Williamson, Struggling to Cope, p. 91.
21 Perry, Perry Graduates, pp. 146-147.
from the townspeople: "a rotting and heinously public welcome at the Corinthian Baptist Church." And even Perry, on that first solitary Sunday in Mexico, Missouri, ultimately found warmth and company at the Methodist Church.

At the conclusion of the services the presiding elder said, "For many years we have been planting an orchard in Nashville, Tennessee, that has been bearing fruit. All of these years I have not seen until the other day a single apple in an orchard from our orchard. If you were to spend money and time in growing an orchard, surely you would not be so silly as to say I will not use the fruit from my own trees. I have something to show you this morning that you have never seen before, a colored doctor, an apple from your own orchard."

Those were the words of the presiding minister in the way of introduction. To me this was a surprise, but I persevered to have a bountiful supply of cards, which were generously distributed as the crowd surged forth to shake my hand at the conclusion of my remarks.

Any new physician, white or black, arriving in a town would have experienced the same variety of feelings as those described here, their intensity depending on previous training, knowledge of the town, tone of personal finance, and personality. But race added an extra measure of uncertainty to the arrival of a black practitioner. As the Mexico, Missouri, minister indicated, in the late nineteenth and early twentieth centuries few blacks and even fewer white lay people or physicians had ever courted and dealt with, personally or professionally, a black with an M.D. So the same black citizens who accorded black physicians high status in the community because of educational superiority, professional position, and earning potential also treated wardly someone so different from themselves who took on a role ("doctoring") usually reserved for whites.

Biographical and autobiographical sketches of black physicians during this period indicate that they assumed high posts in their churches, service organizations, and social clubs, and acted as liaisons with white community and civil authorities. Blacks, wrote one graduate of Leonard Medical School practicing in Mazon, North Carolina, "generally seem to appreciate their people and yet the [black] doctor is such a strange man to a great many, they have to hesitate and look him up and down." That is exactly what Perry encountered after Mexico's daily newspaper announced his presence: "For the first few days," he wrote in his autobiography, "as I passed on the streets, one person would call another and the two, a third"

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20 Perry, Perry Cook, p. 145.
24 "William A. Mapp to Mehl, 30 December 1896, Letter File 1, Law archives.
25 Perry, Perry Cook, p. 146. See also John H. Tompkins to Mehl, 7 December 1896, Letter File 1, Law archives.
26 Tompkins to Mehl, 7 December 1896, Letter File 1, Law archives.
Now, nobody disputes the right of a Negro to practice medicine. . . However, there is room for doubt that . . . [additional] Negro doctors would find the demand and reward for their labors considerable enough to pay expenses to keep themselves alive. An indissoluble something resides in the breed that disdains the Negro to give countenance and patronage to members of his own race.\textsuperscript{30}

That "indissoluble something" keeping black patients from using black physicians’ services resulted in part from a reluctance to give up traditional reliance on white doctors and from a sense of uncertainty about black physicians’ abilities. For years slaves had heard white racist assumptions about black incompetence and seen only white healers when sick, leaving many former bondsmen and their descendants presuming that only whites were capable of learning and practicing regular medicine. In addition, self-doubt in times of sickness was common among blacks. For rural dwellers without ready access to physicians’ services, self-reliance in medical matters was a necessity. Such independence from professionals, born of necessity, became habit, except in severe situations. And medical intervention, even in the early twentieth century, did not mean certain cure. Medical knowledge was increasing, but primarily in the area of diagnosis rather than treatment. Blacks, even in slavery times, when they were supposed to report ailments to masters or overseers, often first used treatments they had brought with them from Africa and the West Indies or had developed in the American South and had shared with others in the slave quarters.\textsuperscript{31}

They continued to apply these remedies and try our others after the Civil War, especially now that freedom had removed the watchful eyes of their former owners to other matters.

Freedom also allowed the more open practice and flourishing of another activity that interfered with blacks’ acceptance and use of regularly trained black practitioners—rootwork. Based on a belief in the supernatural and on the magical powers of “conjurors” to control events in people’s lives, this system, brought with slaves from Africa to the West Indies and then to the United States, had a large following among late nineteenth-century Southern blacks. Conjurors, adherents believed, could, through herbs and voodoo, bring on or relieve people of diseases and physical disorders at will, when asked (and paid) to do so.\textsuperscript{32} Regular physicians and lay observers, black and white alike, denounced these beliefs as supersti-

\textsuperscript{30} Undocumented article in the Washington Post reprinted in NNPA, 1910, 2: 46–47.

\textsuperscript{34} See references in n. 25.
doctor"

Less obvious but more insidious than the disliked or lying black healer who came and went in a short time was the well-entrenched but incompetent physician who undermined the standing of fellow doctors. Walter F. White, executive secretary of the National Association for the Advancement of Colored People from 1931 to 1955, described such a man in his 1924 novel, Fire in the Flint, about the return of Dr. Kenneth B. Harper, trained in the North, to practice in his hometown of Central City, Georgia:

Perhaps the greatest factor contributing to the coloured folks' lack of confidence in physicians of their own race was the inefficiency of Dr. Williams, the only coloured doctor in Central City prior to Kenneth's return. Dr. Williams belonged to the old school and moved on the theory that when he graduated [from medical school] some eighteen years before ... the development of medical knowledge had stopped. He fondly pictured himself as being the most prominent personage of Central City's Negro colony, was pompous, bulbous-eyed, and exceedingly fond of long words, especially of Latin derivation ... Through his fraternal [society] and church connections and lack of competition, he had made a little money, much of it through his position as medical examiner for the lodges to which he belonged. As long as he treated minor ailments — cough, colic, childhood warts, and the like — he had little trouble. But when more serious maladies attacked them, the coloured population went for the old white physician, Dr. Bennett, instead of for Dr. Williams. 49

White makes it clear that Bennett was only somewhat more competent than Williams but that even so, it took young Dr. Harper some time to overcome the prejudice against black physicians that Williams had engendered in Central City's "Negro colony." Only perseverance and successful medical outcomes could win over blacks who had had bad experiences with other black physicians. White physicians as a group did not encounter this type of problem because its basis was racial; black doctors had a harder time proving themselves to their potential patients because they were black and doctors a mistaken diagnosis or treatment, a high charge: or perceived insult, a charlatan or unqualified physician, cost black physicians a much higher price than did white physicians.

Drumming up business among reluctant black patients was only one difficulty the black doctor faced upon moving to a new town. His or her presence did more than cause some black patients to consider using a physician of their own race, it often stirred up racial tensions between blacks and whites. Excluded one black woman when, in May 1906, Joseph E. Walker announced himself as the new doctor in town (Indiana, Misc.

49 P. 48.


Black physicians did not worry alone about the effect black doctors might have on local race relations; the physicians themselves had similar concerns. Sometimes they sided away from a particular state or region, as Leonard's President Moseley explained to the citizens of a South Carolina town: "I appreciate what you say about the need of a colored physician in your locality. The fact is, colored physicians do not desire to settle in South Carolina. You, of course, understand why without my saying anything further. I wish it were not so." (See the color/physician ratios in table 2.) And generally black physicians knew that their arrival would upset the balance of patients and incomes that had previously existed among practitioners. Though some whites may have extended a helping hand to their black medical brethren, others held underlying or overt negative feelings as well.

The letter to the Medical World quoted at the beginning of this article illustrates the nature of the problem black physicians faced. Dr. Taylor's editorial response which was printed immediately beneath the letter, ventured "the opinion that (the letter) does not voice the sentiments of southern medical men," and remarked critically on its "literary attainments." Taylor also commented favorably on the good work he knew black physicians were performing in the South and invited their reactions to the letter. 44 Over the next two months Taylor published replies from black and a few white physicians, all attacking the provocative letter's author, denying the existence of his negative, racist attitude among the general population of Southern white doctors, and supporting the efforts of black practitioners. 45 But racism did exist, as this excerpt from a Chilton Forge, Virginia, physician's response inadvertently demonstrates: "The Southern doctor in question represents a very small minority of the Southern white physicians. . . . Simply regard [the letter] as one of the many obstacles which are constantly being thrown in the way of the man of color when he attempts to rise. 46

For away from the limelight, in offices and patients' homes, incidents did occur that revealed some of these other beliefs and feelings of white physicians. A white Southern doctor could write an open letter to the Medical World looking for ways to limit competition from his black colleagues and receive open rebuffs for his views and denials of their representativeness from members of the medical profession; but back home this same man (and others like him) could (and did) act "to keep Negro physicians down." Dr. J. Edward Perry, for example, met with a less than cordial
response from a white Columbia, Missouri, physician to his proposed move
to that town in 1895. In reply to the young black doctor’s request for “the
acquainceance, goodwill and assistance of the [local] representatives of the
profession,” this man informed Perry that “the practice among your people
is done by white brethren in the profession and it would be a mighty hard
thing for a man of your age and more especially your color to win it from
their hands.”

Corroboration of this contentious concern comes from
James Martin’s 1930 Tennessee physician study. He found it generically...
[though not uniformly] the case that white physicians regarded the negro
physician as an economic competitor, so much so in a portion of west
Tennessee that “negroes are forced [by their white colleagues] to charge the
same as whites do.”

Similarly, an Oklahoma physician in 1914 described white
Southerners as “wont” to be “crawling for [patients of the oppo-
site race as an economic asset to their practice.”

Some of these fears about competition from black doctors can be
explained by the state of medicine and the national economy in the late
nineteenth and early twentieth centuries. Black physicians were attempting to
enter medicine at a time of professional overcrowding, when even in
small towns too many physicians were competing for too few patients, and
when economic conditions were at best only fair. But in addition to these
professional and economic issues in the South were racial ones. White
doctors in Tennessee could still pay fairly to a white sociologist in 1930. “Mr.
Martin, you will find that the negro mind is incapable of any considerable
development, and Dr. A., being a colored man, is not to be seriously
regarded as a real physician. He is a good negro, but still a negro.”

And the MCAO executive’s W. E. White, well acquainted with black physicians and their experiences, could, in Fire in the Flint, accurately reflect reality by having an idiotic Georgia practitioner say of a black physician who had corrected his diagnosis and successfully treated his former patient that he “wasn’t go to let no young nigger doctor tell him his business.”

Black physicians in the South, despite glowing reports to medical journals, alumni
and religious missionary magazines, and former teachers, did encounter
racial problems in their practices.

A severe case was white physician’s refusal to consult with or assist black
colleagues in the treatment of patients in extremis. Written descriptions of
such incidents are rare, but their very occurrence indicates the depth of
white antagonism and strength of tradition that some black physicians had

developed.

Not surprisingly, Walter White’s stereotypical fictional white Georgia
doctor behaved like the real-life Dr. Beasley. When the young black
physician in Cerval City sought out a colleague to help perform an emer-
gency operation, “he realized his absolute dependence on Dr. William-
sonesque.”

Such openly racist behavior not only endangered patients’ lives, but also
undercut the position of black physicians before their patients. If black
physicians could not obtain assistance from white colleagues when urgently
needed, how could white doctors be relied upon to treat their patients’
medical and surgical problems? The black physician Luther Burbridge, in
his 1895 Emancipation Day speech, “The Colored Man in Medicine,” in New
Orleans, Louisiana, cited just this type of situation to exemplify the difficulties
facing him and his colleagues. “A surgical operation of importance is to be
performed, and the case falls into the hands of the colored doctor. He
knows that there is little hope of any professional assistance from the
neighboring physician and his future reputation and success depend, perhaps,
Black Physicians in the New South

less rights. There were three reasons for these relentless moments and disturbed emotions. First, a deficiency of knowledge. Second, a lack of contact and clinical advice. Third, desolate facilities.

As Burbridge eloquently described it:

Isolated, as many of them are, from intercourse with colored men of their own profession and despairing of any assistance from the opposite race, often their only recourse is their books and journals. Under such circumstances the Negro physician sometimes finds himself confronted with a deep and seemingly impassable gulf over which it seems impossible to leap and around which he can see no way.

This gulf of isolation based on race appeared almost immediately after blacks entered the medical profession in the 1860s. Alexander T. Augusta encountered it during and just after the Civil War in Alexandria, Virginia, and Savannah, Georgia, in his dealings with white physicians, and then again in 1869 and 1870, when he and two other black physicians applied for admission to the all-white Medical Society of the District of Columbia, and in 1870 to the American Medical Association. It continued to 1882, when Dr. Whiefield W. W. Westley, a Harvard-trained black physician, received seven blackballs from members of the Baltimore Medical and Surgical Society (five were needed for rejection from membership). All voted negatively on account of Westley’s race, one member saying “that his Southern birth prevented him from recognizing a negro practitioner.” And the exclusionary policies extended to all other Southern medical societies through the 1940s.

The gulf that kept black physicians from professional intercourse with white colleagues and medical societies also extended to hospitals. While physicians simply denied admitting privileges to blacks, forcing them to leave patients who required hospitalization (usually for surgery) at the entrance door, contrasted to the care of these same white doctors. This was a particularly difficult problem because it affected the doctors’ pocketbooks, professional competency, and standing with patients. John W. Walker of Asheville, North Carolina, speaking for his son’s black doctors at the 1910 National Medical Association (NMA, the black counterpart to the AMA) annual meeting, described the situation to a group already quite familiar with the problem: “We realize that we are put to a great disadvantage when

we have cases to operate upon and have no hospital. We are obliged to turn (patients) over to white physicians and when we do this it is hard for our people to have the proper interest and confidence in us. Dr. Albert W. Dunham of Natchez, Mississippi, echoed Walker's sentiments, adding: "White surgeons carry the patients to the hospital and often you never see the patient again until they die or recover." Blacks thus had little opportunity to learn and refine surgical techniques once out of medical school, or to provide continuity of care for their patients. Few blacks became surgical specialists, and many lost income because of their actual or presumed inability to perform surgery or because they could not provide needed hospital medical care. In several ways, then, white physicians in the South isolated black practitioners and so reduced blacks' effectiveness as doctors.

Income was another matter that caused tension between black and white physicians in this era of economic stagnation (especially in the rural South). At times, the entry of black physicians into an already crowded profession worsened existing racial stress. White practitioners appear generally to have surrendered their nonpaying and indigent black and white patients to the new black doctors without strong protest. But black physicians, like white physicians, had to feed their families. And some, perhaps most, had ambitious besides healing and teaching better health practices to the poor. They were professionals who wanted to make names for themselves and at least live in comfortable homes like their white colleagues. This meant competing for patients with white physicians. Walter White's fictional (though representative) Kenneth Harper explained one day to his brother why he returned to Georgia after completing training at Bellevue in New York City:

"Why did I come back? That's say, I come back because I can make more money here than anywhere else...... I came back here where the bulk of coloured people live and where they make money off their crops and where there won't be much trouble for me to build up a big practice. Oh, I suppose I could've made money [in the North]...... but I wanted to come back home. I can do more good here, both for myself and for the coloured people, than I could up there. And I don't think I'll ever have any trouble down here. Pigs eat along all right here in this town for more than fifty years, and I reckon I can do it too...... Why, I'll have a clinic around this part of Georgia! There aren't more than half a dozen coloured doctors in all this part of the country who've had a decent medical education and training...... In a few years I'll be able to give up general practicing and give all my time to major surgery. I'll handle pretty nearly everything in this part of the State." 80

ted, was not always positive: "I have experienced some prejudice among my white friends. We do not have much to do with each other as physicians."

Evidence indicates that, though black physicians attracted some of their white clientele because of professional reputations, they also won white patronage for two less glamorous reasons. Perhaps in recognition of the generally low incomes of their patients, or perhaps in order to draw patients to their practices, some black physicians charged less than the usual fees for medical services. These doctors did not appear to have written to their colleagues, former classmates, or instructors about the practice, nor did newspaper, medical journal, or popular magazine accounts mention it. But James Martin, studying Tennessee black physicians in 1920, discusses its silent but pervasive presence in two very different regions of the state, and documents its persistence even when forbidden by white practitioners. Martin reported that the cost charged of fourteen black physicians in five middle Tennessee counties (Lincoln, Giles, Marshall, Maury and Williamson) and eleven in two western Tennessee counties (Haywood and Fayette) were "from 25 percent to 60 percent less than white doctors received" for the same kind of work. Several of the black practitioners told Martin they had "built up a considerable general practice among white people," a practice Martin discovered upon further investigation "to be for the poorer white people, who called on [them] colored physicians because their fees were lower." Their clientele among white professional and business classes he found to be "very limited," with the exception noted below.

Concerned about losing patients to black physicians, the white doctors of Tennessee's economically poor and predominantly agricultural "black belt" counties tried actively to compete for Negro patients. Martin described the situation and black physicians' answer to it: "The general custom in the Western counties seems to be that the white physicians give directions as to those matters [of fees charged] which the colored must obey. As a matter of course, these are often exacted, but secretly." The experience of white and black practitioners in seven Tennessee counties does not necessarily represent a situation that prevailed in the South. But the poverty of most late nineteenth- and early twentieth-century Southern blacks—the group that constituted the majority of black physicians' patients in the region—surely dictated that black physicians establish a lower fee schedule than that of their white colleagues. And these cheaper prices must have induced some poorer whites to call on black doctors when sick. Whether these practitioners were also more lenient in their collection schedules is not well documented. Lower fees, however, if they cut into the practice of local white physicians, would understandably have upset the white physicians.

If a difference in fee scales between physicians of the two races is difficult to document, the other reason some whites preferred black doctors to those of their own racial group is even more difficult to document because of its delicacy. This aspect of Southern black physicians' practice white doctors could not control, as it took place secretly. One fictional account of black medical practice in the South does confront the subject of venereal disease treatment directly. The author Walter White describes how Dr. Kenneth Harper began treating certain affluent, respected white males of Central City, Georgia, in the early 1920s:

A new source of practice and revenue began gradually to grow. The main entrance to his office was on Lee Street. This door was some fifty feet back from Lee Street, and the overhanging branches of the oaks cut off completely the light from the street lamp at the corner. One night, as he sat reading in his office, there came a knock at his door. Opening it, he found standing there Roy Finga. Finga had inherited the general merchandise store bearing his name from his father. He was a deacon in the largest Baptist church in Central City, was president of the Central City Chamber of Commerce, and was regarded as a leading citizen.

Kenneth gazed at his caller in some surprise.

"Hello, Ken. Anybody around?"

On being assured that he was alone, Finga entered, brushing by Kenneth to get out of the glare of the light. Kenneth followed him into the office, meanwhile asking his caller what he could do for him.

"Ken, I've got a little job I want you to do for me. I'm in a little trouble. Went up to Macon last month with Bill Jackson, and we had a little fun. I guess I took too much liquor. We went by a place Bill knew about where there were some girls. I took a fancy to a little girl from Adana who told me she had stepped away from home and her folks thought she was visiting her cousin at Foynt. Anyhow, I thought everything was all right, but I'm in a bad way and I want you to treat me. I can go to Dr. Bennett 'cause I don't want him to know about it. I'll take care of you all right, and if you get me fixed up I'll pay you well."

"That," concludes the narrator, "was Kenneth's introduction to one part of the work of a colored physician in the South."

James Martin found evidence of this work in Tennessee. One physician he interviewed said: "When a young fellow of the aristocratic class, and this is an aristocratic town, gets ahhit [sic] or gonorrhea, he usually goes to this negro [physician] and so avoids the embarrassment of submitting such a case to a friend of the family." A few black doctors there developed a reputation for curing venereal diseases and attracted a large black and white

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1. Tylloux, Colored Medical Men; p. 89.
3. Ibid, p. 82.
5. Ibid, p. 80.

Some black physicians in the South encountered similar problems and acted in a similar manner.

6. "Some Black Physicians in the North encountered similar problems and acted in a similar manner."

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7. White, Fee in the Saloon. pp. 63-64.
8. Ibid, pp. 64-65.
...the physician in the New South... and house, and real estate valued at fifteen hundred dollars in a fine portion of the city, within four blocks of Main Street, the business center of the city.

Several available reports announce strikingly positive public responses to black practitioners' arrivals, responses that conveyed the promise of friendship and collegiality among potential rivals. Theodore A. Walker of Baton Rouge told readers of the Christian Educator in January 1887, "I was given the hand of fellowship by a leading white physician, Dr. J.W. Dupree, who welcomed me in these words: 'You are my colored medical brother, and I will go with you at any time.' And Robert F. Boyd of Nashville, a graduate and future faculty member of Meharry, wrote, 'All the physicians of the city treat me white.' I have, when needed, wrote Green J. Barnes from San Antonio at this time, 'counsel from the leading physicians of the city.' Another black doctor in Texas had 'the respect of all the physicians of this city, one of whom made me a present of one hundred dollars' worth of good medical books.' President Meharry, who received numerous letters from graduates in practice, most living in the South, bragged in his 1903-4 annual report to a philanthropic fund that his school's alumni 'are respected by the white physicians wherever they go, and have no difficulty in getting the white physicians to consult with them when critical cases demand it.' Such was the skill and reputation of a Columbia, South Carolina, practitioner that he reported to W.E.B. Du Bois being often 'called upon by white physicians to consult with them in medical cases and assist in surgical cases in their practice.' Race seemed not to interfere with professional matters for these physicians. One North Carolina doctor summed it up by stating; my intercourse with the white members of my profession is cordial along professional lines. I seek no others.'

Acceptance by white colleagues represented one measure of success for the black physician. Patronage by patients and the financial rewards that accompanied it represented another. Young black doctors happily reported their progress, though, as Du Bois cautioned readers of his study of "the college-bred Negro," there were many failures. But people tended to discuss the good and ignore the bad. So letters to Du Bois, Meharry, George W. Hubbard (dean of Meharry), and others emphasized accomplishments."

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52 Ibid., p. 115
53 Ibid.
54 Ibid., p. 124
56 Du Bois, "College and Negroes," p. 85
58 Du Bois, College and Negroes, p. 85
come and assist their black colleagues as they might have taken a newly
graduated doctor of their own race under their wing contributed to the
cause of harmony between black and white professionals. But they did not
change the mores of Southern society. Whites still dominated, prejudice
and segregation still existed. So the success of black physicians depended
not only on their pastive receiving welcomes from a few sympathetic white
physicians and some local black patients. These doctors had actively to
overcome negative white and black racial attitudes toward black medical
professionals. They did this by practicing good medicine, by proving them-
Themselves competent, by becoming leaders in their communities, and by, as
will now be shown, addressing directly some of the obstacles others put in their
path.
Black physicians fought against professional isolation in several ways.
Personal contact with white physicians sometimes helped. More fruitful
were activities that sought to circumvent the formal racial isolation imposed
by whites. Though these methods simply established parallel segregated
institutions for black physicians, they did provide professional opportuni-
ties that were otherwise unavailable. These practitioners acted to improve
their situations not only at the local level, but also regionally and nationally. A
key to all these endeavors was good communication among local black doctors.
That, of course, was easier to do in urban areas than out in the country.
A glance at city or medical directories of the period reveals the presence of
more than one black practitioner in towns of any size in the South.4 Numbers
allowed them to discuss ways of protecting their interests and to band together
in formal and informal ways. Occasionally blacks in a city established a local
medical society and met regularly for professional or social purposes (see table 4).
In May 1911, for example, the physician members of the Pulls City (Louisville)
Medical Association met and estab-
lished a fee schedule "in order to secure uniform prices and insure reason-
able rates of service to the public."45 Other physicians simply recognized
common needs and acted to assist one another. A black physician in
Columbus, Georgia, for instance, helped a recently arrived Leonard Medical
School graduate establish his practice in town.46 To turn-of-the-century
Kansas City, Missouri, J. Edward Perry reported in his autobiography, the
need for a united front was great:
Those were tough days and lean pickings for the Negro doctor of Kansas
City. We soon learned that the interest of one was the welfare of the other. The
objective was to gain a reputation for the efficiency of the brother of color.

48See, for example, Perry, Perry City, pp. 195-96; John H. Tompkins to Haver, 7 December 1886,
Letter File 1, Shaw Archives.

49See Seeley and Jenkins, "Some New Words in the literature of the period and John M. Haver, "Studies in Race Relations in

50James Henderson, "Freeman of a black medical profession?" in Race, 1880-1930" (J.J. Tirade

51 J. H. Williams to Haver, 13 May 1914, Letter File 1, Shaw Archives.
Our greatest difficulty was continuing in the service of a patient after having been called. If a patient were admitted in his "tumany" and was not entirely relieved by noon the following day, a white physician was frequently called if per chance the individual had the cash in hand. Blacks were of no significance at all to the white brother. It appeared to be the "survival of the fittest."

Often when an individual became seriously ill with pneumonia or typhoid fever, and one of the group perished to be in the neighborhood, a call would

Table 4. Black Medical Societies in the United States, 1914–15

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<td>State and regional</td>
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<td>The Atlanta Association of Negro Physicians, Dentists, and Pharmacists</td>
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<td>The Richmond Medical Society of Richmond, Va.</td>
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Cooperation among black physicians even extended to poor rural areas of the South, for no other reason than to exchange information about fees and patients. Though perhaps not as well organized or successful as urban groups, these networks appear to have been useful. James Martin's brief statement about the physicians of middle and western Tennessee indicates that such arrangements existed elsewhere, as well: "Agreements among negro physicians as to case charges seemed to be not very precise; but, in most places where there are two or more practicing, there are such agreements, indefinite and poorly kept as they are." 176

Forming local societies, arranging fee structures, and providing mutual patient coverage were only some of the actions black doctors took to bolster their professional positions and combat isolation. Another major problem they faced was gaining access to hospitals. So black practitioners established their own, either individually or in groups, where they could care for their patients and perform surgery.176 When, for example, Cornelius and Alice Woody McKeen arrived in Savannah and found no hospital, they made it a priority of theirs to open one. In 1895 the McKeen Hospital began accepting patients and continued to care for blacks using black physicians long after its founders had left for Africa in 1895 as medical missionaries.177 The pioneering South Carolina physician Matilda Evans opened hospitals in Columbia three times between her arrival in 1898, fresh from Woman's Medical College in Philadelphia, and 1916.178 Alonzo McClernon, a Howard graduate, gathered enough black community support to open a hospital and nurse training school in Charleston in 1897. All but one of the local black physicians joined with McClernon in the project, which gave them their only chance to obtain hospital operating privileges.179 An enter-

179 Report of W. T. B. Williams on Hospital and Training School for Nurses, 26 November 1916, pp. 6–7, 11. In General Education Board Papers, box 255, Folder 1099, Federal Agency Records, Mark Twain Library, the Waring Mineral Library, Medical University of South Carolina, Charleston, also has a file of materials on this school.

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Black Physicians in the New South

on it into a hospital equipped for surgery. With the support and assistance of black physicians and dentists in the area, Home Infirmary grew over the next few years into a regional hospital caring for hundreds of patients. To help spur on people like Burt, successful black surgeons like Daniel Hale Williams and George Cleveland Hall, both of Chicago, traveled through the South in the early twentieth century, holding surgical clinics for fellow practitioners. These men would perform procedures on local patients in order to demonstrate surgical techniques and innovations to blacks barred from or unable to attend postgraduate courses and white hospital clinics. Anestzing to the influence of surgical clinics and to the fact need for and determination of Southern black practitioners to establish hospitals is Monroe Work’s invention of such institutions in his Negro Year Book. In the 1914–15 edition, for example, he listed seventy-seven hospitals in the region, almost all operated by blacks.

Though expensive for practitioners both in direct costs and in lost patient revenues, taking postgraduate courses in the growing specialty areas offered isolated black physicians a chance to improve knowledge and skills, meet new colleagues, and visit large Northern cities like Chicago, Boston, New York, Washington, and Philadelphia. These courses were initially held at traditional white medical schools and were closed to blacks, but most institutions had begun to accept blacks, and some black educational facilities had established postgraduate programs, by the decade following 1910. (No Southern black institutions developed postgraduate facilities before 1920.)

These sorts of individual initiatives and cooperative ventures, aimed at overcoming professional isolation, encouraged some black physicians to link colleagues on an even broader basis. In 1895, enough physicians expressed interest in founding a nationwide medical society that a group met in Atlanta at the Cotton States and International Exposition, the same exposition at which Booker T. Washington gained notice for his famous accommodationist speech to establish the National Medical Association, with gods similar to those of local groups. And by 1920, virtually every Southern state had a black medical society that sometimes included dentists and pharmacists along with doctors (see table 4). Such groups met regu-

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pring 1891 Meharry graduate, George S. Burtus, moved to Augusta, Georgia, and in 1901 established a hospital there. Five years later a reporter for a national black magazine described the Bursaus Sanitarium for his readers:

It consists of a large three-story frame building, which contains twenty-seven rooms and one ward. The rooms are well ventilated, handsomely furnished and are provided with electric bells and electric lighting apparatus. The operating room is equipped with all the requisites of modern and aseptic [sic] surgery, including the operating table, instrument table, two wheel stretcher, a microscope for examining blood, spurtum, etc., and an amphitheatre for the convenience of doctors, nurses, and others who are privileged to be present during an operation. Not far from the operating room is the X-ray Departure, in which there is an X-ray machine which was installed at a cost of more than $900. The first floor is taken up largely with a drug store, of which Dr. Burtus is sole proprietor, with his private offices and a large public reception room. The Sanitarium, building and equipment, is valued at $10,000 and is free from debt.

The other eleven black physicians in Augusta, according to the writer, offered their "services and active hearty cooperation" to the enterprise. Of course not all or even most black physician-run hospitals succeeded like Burtus’s. Little towns and rural areas required such facilities on a smaller scale. Nor were there always patients to occupy the beds or make use of the equipment. In the seven Tennessee counties he studied, James Martin found three hospitals, only one of which still functioned. In stark contrast to the Bursaus Sanitarium, this facility comprised "a large, almost bare house in which there were a number of beds. There were, at the time of this visit, no patients and hence no nurse or caretaker other than the physician whose office was next door."
The other two hospitals Martin investigated were cooperative ventures among two or more black physicians. Whether owned individually or by groups, these private hospitals sprang up across the South as black physicians encountered racial restrictions on their practices.

Like Kenneth Harper of Central City, Georgia, some black physicians had aspirations of becoming experts in surgery in their regions and founded hospitals as the only available means to achieve that goal. Robert C. Burt (Meharry 1897) of Clarksville, Tennessee, was such a man. According to biographical sketches in his personal papers, he nourished a "long cherished dream of opening a small hospital and to do surgery on a large scale." So in 1904 he bought some land and by 1906 had converted a house


203. Ibid.
early to present medical papers, to exchange information and ideas about racial matters, and simply to socialize and become acquainted with colleagues. The fifth annual meeting of the Mississippi Medical and Surgical Association in April 1895 was typical. The Jackson gathering offered those attending case presentations, medical papers and discussions, and a presidential address that stressed, according to a local newspaper report, "promoting friendly co-operation with the white physicians of the state, and spoke in the highest terms of the white physicians generally." In an obvious reference to these remarks, the white newspaper approvingly included in its headlines for the story the words "President May Makes a Good Talk In Which He Gave His Association Sensitive Advice." 129 All these organizations experienced difficult times when membership or attendance at meetings dwindled, but most survived until integration.

Black-oriented medical journals also provided a means not only of keeping physicians' knowledge current, but also of learning about colleagues' and institutions' activities and of contributing information of one's own. Miles Vandiburst Lynk of Jackson, Tennessee, published the first of these journals, the Medical and Surgical Observer, in 1892, less than one year after his graduation from Meharry. A forceful and outspoken man on many subjects, 130 Lynk promoted his periodical with advertisements such as this:

Say, Doctor, have you read the Medical and Surgical Observer, the Organ of the Colored Medical Profession of North America? It recognizes the necessity of a higher standard of medical education in this country, and will put forth its best efforts to raise and maintain the same. It contains all the progressive ideas of the profession—minus the chaff.

Read and endorsed by the profession from the Atlantic to the Pacific and from the Arctic Ocean to Mexico. 131

In the days before black physicians had organized a national professional association, Lynk's advertisement struck of hyperbole, but if the letters he published from readers around the country indicate the journal's general reception, then the Observer certainly filled a gap. One such letter from Waco, Texas, read:

I have before my gaze the pride and boast of every Negro doctor—a journal of our own—a counterpart of ourselves—a real living proof of capacity in science and art. In a brief way, allow me to congratulate you for your self, energy and foresight. The accomplishment of a century in twenty-seven years [since Emancipation]! Who can say (but to be laughed at) that we are not coming one hundred thousand strong? God bless your efforts, provide for the permanence of such a literature and endow the editor with wisdom. My name, accompanied with subscription price of your valuable journal will be forthcoming in a few days. 132

Though lively and interesting, the Observer could not (nor could its editor) allure enough black physicians to part with one dollar for a subscription to sustain the publication beyond 1895. Lynk, however, remained active in the profession, calling for the establishment of a nationwide professional society in 1892, and operating the University of West Tennessee School of Medicine almost single-handedly, first in Jackson, then in Memphis, from 1900 to 1922. 133

Not until 1909 did a second national medical journal by and for black physicians appear. (Alonzo McClenathan had published the Hospital Gazette in Charleston for a few years in the late 1890s, but its audience remained local and oriented toward nursing.) 134 At that time the officers of the National Medical Association began issuing an official Journal. It, too, struggled for survival, but endured hard times, strongly promoting the interests of black physicians. It published papers presented at annual meetings, minutes of NMA and state society meetings, and advertisements of upcoming black-sponsored medical meetings and events. Individual physicians reading the JNMA could feel part of a larger group and learn how and where to participate, if desired.

The JNMA published editorials as well, offering opinions on important aspects of black medicine. In 1920 the death of a prominent practitioner, Dr. George W. Cahabas, provided the editors with an opportunity to look back at the growth of the black medical profession and at the measures of success black physicians had been using. They found their colleagues wanting.

Too many men in the practice of medicine feel that when they have made money and established their economic independence, they have discharged their whole responsibility to their day and generation. . . . Let such a physician step for a moment and consider how he has made his money—from where he has made it. . . . We venture to say that about ninety-nine per cent of [his] practice is among Negroes, and we venture to say further that ninety-nine per cent of that ninety-nine per cent is among the hard-working class of Negroes, the poor, the lowly, the ignorant—that mass of helpless dependents, many of them absolutely poverty stricken, living from hand to mouth. Doctor, when you drive through the slums in your high-powered, fast-going automobile and look upon this suffering mass of disease-ridden, poverty stricken [people], ignorance personified, out of whom you have gained influence and opulence, do you stop for a minute to think that you owe them anything in return? . . .

129 Jackson Daily Citizen Ledger, 27 April 1917, p. 4; thanks to Thomas N. Borchert of Decatur, Mississippi, for the reference.] See also Sturman, "Penmanship of a black medical professor in Tennessee;" pp. 644-46.
131 History of the Negro in Medicine, p. 84.
132 [Hill, J. M., 1911, 1 page.
133 JNMA, 1909, 4: 17.
The editors raised difficult questions for successful practitioners, questions these doctors had avoided or pushed aside in their pursuit of other goals, but which they would eventually have to confront.¹⁷

By 1920, Southern black physicians had come a long way in establishing themselves. Though they could never escape the race issue, in their dealings with both patients and colleagues, many had earned a good reputation and a good living. As a group they had developed an increasingly strong, active, and accepted body of medical professionals. Their commitment to the general improvement of black health may have suffered in their zeal to establish themselves and provide an enduring presence in a previously white profession. But they had made a good start in accomplishing their other goals.

¹⁷See Browder, "Making Sense, Equal."