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Healthcare Denied and Revived: 1896–1970
A Mississippi Case Study

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ABSTRACT

Health is both a civil and human right. However, the United States has historically treated health and healthcare as solely a civil right that can be selectively granted and revoked, rather than as a human right. Healthcare has been cast into the periphery of segregation and desegregation discourses, just as black populations' access to care has been minimized. We lose out on the evolution of health activism, and its dominant actors, throughout monumental institutional changes when these issues remain out of focus. To reinforce the magnitude of racism, the author makes use of the stories of Dr. Charles R. Drew and Juliette Derricotte, who died preventable deaths. The research centers healthcare in the civil rights discourse by examining the evolution of healthcare in the South before and during desegregation as it relates to the dominant actors of healthcare activism in the Mississippi Delta, particularly in Mound Bayou.

Keywords: healthcare activism, human rights, segregation, Civil Rights Movement, Mississippi

Basically, you can't separate medical problems from social, economic, and political ones, nor can you neglect the health of one racial segment or class without damage to the health of all.

—Edward C. Mazique, M.D.
The Milwaukee Sentinel
August 14, 1958

Spencie Love's *One Blood: The Death and Resurrection of Charles R. Drew* (1997) follows the life of Dr. Charles Richard Drew, a well-known surgeon and research professor at Howard University's medical school. Dr. Drew became famous for his groundbreaking research and work in blood plasma and in helping to establish the first American Red Cross blood bank. However, all this fame and potential were suddenly ceased after a long, nighttime drive from a conference in Alabama on April 1, 1950, when Dr. Drew and his passengers wound up in a car accident in Alamance County, a rural region of North Carolina. Rumors began to spread that Dr. Drew and the passengers were refused emergency care because of his race. The truth was that Dr. Drew was treated by two white surgeons in a segregated emergency room of the Alamance General Hospital. Dr. Charles Richard Drew was, in this way, a legend in life and death. Even though the rumors were untrue, they spoke volumes about American discriminatory practices toward African Americans, especially in the South (Love 1997, 1–5).

The story of Juliette Derricotte provides a striking parallel to that of Dr. Charles Richard Drew. Juliette Derricotte was an African American educator from Athens, Georgia, who showed

much potential in her years as a student leader at Talladega College, and then as the Dean of Women at Fisk University in the early 1930s. She was stopped short of her future leadership potential when a white couple's vehicle collided with hers about a mile outside of Dalton, Georgia. The car carried three other passengers who were students at Fisk University. Derricotte and one other passenger were seriously injured and in need of emergency treatment, however the nearest hospital refused admission to African Americans. At that time, skin color could cause a person to be stripped of their humanity and added to an exhaustive list of preventable deaths due to healthcare denial. Derricotte and the injured student were relegated to the care of a local black woman who offered beds for refused black patients. The student died that night and Derricotte died on November 7, 1931 (the next day), after her ambulance ride to Walden Hospital in Chattanooga (Love 1997, 1–5; Gale Research 2002). Such stories prove that racism is a living, evolving entity that can pervade every institution.

The stories of Dr. Charles R. Drew and Juliette Derricotte, even with fictitious discrepancies, highlight the all-too-common narrative of healthcare denial for African Americans in the South. Credentials, respectability, and professionalism were not enough to grant them the highest care attainable. Jim Crow refers to the segregation laws that subjugated African Americans, giving blacks a lower quality of US citizenship and forcing them to use separate public facilities between 1877 (the end of Reconstruction) and the 1960s. The US healthcare system under Jim Crow (and even in the present) was simply not built to care for everyone's healthcare needs. It has acted more as a rationing mechanism for care commodities and privileges. Yet, with the understanding that healthcare discrimination can be deadly, healthcare should be approached as a human right. Human rights are necessary and inherent to human existence and, for this reason, should not be taken away ("What is the Difference Between a Human Right and a Civil Right?" n.d.).

The concept of human rights was popularized in 1948 with the end of World War II, after the gross discrimination toward and torture and killing of Jewish people (University of Minnesota, 1998). Article 25 of the Universal Declaration of Human Rights of 1948 addresses healthcare as a human right with the following:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.

The World Health Organization (WHO) also created a constitution in 1948 that fortified health as a human rights issue. The preamble includes 3 primary principles that apply to this research and is paraphrased as follows: 1) that health is a holistic state of being that includes physical, mental, and social well-being in addition to a biological one; 2) that the highest attainable standard of health is a fundamental human right granted without consideration of race, religion, political leanings, or socioeconomic condition; and 3) that governments have a responsibility to ensure the health of their citizens through adequate provision of social and health programs (WHO 2018). Before 1948, rights had usually been described through the lens of civil rights granted by citizenship (University of Minnesota, 1998). Civil rights can serve as protection against discrimination, and because of this fact, healthcare can be categorized as both a human and civil right. According to my observations, the original ideas of citizenship had always been in question for African Americans and this made healthcare denial that much easier until the Civil Rights Acts of 1964.

This paper specifically discusses the history of Mound Bayou and the surrounding towns of Mississippi in a case study that exemplifies the changes in the political exemption of African Americans from the healthcare system over time. In the 1960s, poor Americans were four times more likely to die before age 35 than those who could afford appointment fees and transportation costs. African American women who resided in Mississippi were six times more likely to die during childbirth than their white counterparts. Furthermore, the average life expectancy of African Americans was 61, while white individuals lived an average of 68 years (*The New York Times*, 19 May 1968). Many physician-activists and community leaders employed the aforementioned human rights view of healthcare in their activism for healthcare access. Health care providers and civil and human rights organizations alike worked toward the common goal of providing care to African Americans, even when formal healthcare institutions deliberately chose not to. The following questions concerning Mississippian experiences with medical discrimination have directed the research resulting in this paper: What were the forces of medical discrimination that black communities and health activists had to fight against? What were some of the barriers to creating sustainable healthcare delivery interventions? How did the ideologies during medical desegregation differ among black healthcare providers? How did formal medical facilities (hospitals) deal with desegregation? Through the discussion, the reader should gain a sense of the magnitude and breadth of racial discrimination, its effects on African American health, and the ways in which black communities, organizations, and physician-activists attempted to extend healthcare delivery beyond the racist and classist limitations of the US healthcare system.

Mound Bayou, Mississippi is a rural and historically African American town that was established in 1887 by two African American cousins, Isaiah T. Montgomery and Benjamin T. Green (Beito 1999, 183). Since Mound Bayou's inception, the town has faced a plethora of challenges regarding healthcare – before, during, and after Jim Crow laws were implemented. Healthcare in Mound Bayou was severely diminished given its poverty rates. According to Dittmer's *The Good Doctors*, six physicians took a tour of the Mississippi Delta and witnessed the disturbingly diminished level of health in the area. The physicians found rampant malnutrition and starvation, and other illnesses related to the destitute environment. Children had swollen bellies and were fed scraps by neighbors (Jack Geiger Collection, Folder 316). The conditions of Mississippians were especially shocking to these physicians since they were used to much higher levels of health, up-to-date technology, and more medical personnel in the Northern states. In 1969, Dr. Jack Geiger, an avid healthcare activist during the civil rights era, declared Mound Bayou, Mississippi, to be in a state of a public health emergency based on the town's water levels and sanitation system. Geiger determined that the water levels were too low to be properly chlorinated and that the sewage system was "suboptimal." With the lack of water infrastructure, residents of Mound Bayou were made susceptible to infections such as Shigella, gastroenteritis, and viral encephalitis (Jack Geiger Collection, Box 1. "Water Crisis 1969"). However, there was no improvement in the quality and access to healthcare services until after the civil rights movement.

As the stories of Dr. Charles R. Drew and Juliette Derricotte illustrate, white-operated facilities vehemently refused to admit African American patients in Mississippi. If they were treated, these patients were subjected to humiliating second-class treatment, even in the face of illness and possible fatality. Some medical facilities would have separate wings of the hospital for white and African American patients. Others would not permit African Americans to enter the facility through the front entrance, forcing them to enter through the back. Other means of

second-class subjugation and humiliation included requiring African Americans to bring their own overnight toiletries and linens. Those African Americans who could afford an appointment and the transportation costs of admission to a white facility still had to bring their own toothbrushes, towels, sheets, and other overnight materials (Beito 2000, 183). Furthermore, there was a lack of physicians present in the rural, predominantly African American town of Mound Bayou. Most white physicians practiced in white-owned and operated hospitals that were situated in densely populated, and predominantly white urban areas. In fact, there was only a total of 55 African American doctors in Mississippi in 1960 (Dittmer 2009, 5).

Most African American physicians deliberately chose against practicing in rural, low-income areas such as Mound Bayou. However, African American physicians were caught between a rock and a hard place when it came to their medical practices and their politics. Conservative ideologies were one barrier that kept African Americans from practicing in these areas. Establishing a medical practice in an area such as Mound Bayou would not prove to be lucrative enough for some outside African American physicians. Usually, African American physicians wanted the same luxuries that the medical degree afforded white doctors. Sacrificing prestigious leisurely activities was synonymous with practicing in rural, low-income areas. African Americans could not fully exploit the material gains that could follow their degree when not practicing in a wealthier, urban population (Dittmer 2009, 6). For those African American physicians who did have the desire to practice in rural areas, their scope of practice was narrowed. Dr. Douglas L. Conner describes the politics surrounding African American medical practice in Mississippi in his book *A Black Physician's Story: Bringing Hope in Mississippi.* Dr. Conner gives the example of discriminatory actions from national medical societies such as the American Medical Association. African American doctors were also denied hospital practicing privileges and even access to African American patients. Lastly, internalized ideas that positioned white facilities as inherently better also hampered African American medical practices. Potential African American patients would bypass African American physicians in favor of white institutions that were seen as being of better quality, even if these patients were getting less dignified treatment. One white physician, Dr. Tumminello, exemplified, in a *Boston Globe* article from July 17, 1967, the white provider perspective toward African Americans:

> We give the very best advice we know, we tell that nigger he's got to establish a private physician-patient relationship and we even tell him where the nearest doctor is located (Jack Geiger Collection, Folder 320).

Another example from *The Boston Globe* article provides further insight into the treatment of African American patients: "if there is a nigger in my waiting room who doesn't have $3, he can sit there and die. I don't treat niggers without money" (Jack Geiger Collection, Folder 320). Furthermore, the same article bolsters such views from white physicians. This issue is amplified by a quote from an African American who had received medical care from white physicians: "Most oft I sits on one side of the office and he sits on the other asking questions. There ain't no listening or thumping or looking in the mouth like white folks get." A black mother describes the "Wait and See treatment" that her 14-month-old girl and 3-month old boy and many other African Americans were subjected to if they were without funds or access to physicians: "There's nothing I can do for 'em. There's no doctors and I got no money for a hospital. All's I can do is wait and watch, either they get better or they gonna die. I cain't do nothin' but wait and pray." These passages describe well the faces and fates of healthcare neglect for African

Americans in Mississippi before the passage of civil rights laws (Jack Geiger Collection, Folder 320).

However, even with the lack of willing physicians, white or black, this Mississippian community found a way to insert itself into the negligent healthcare system. In the "Years of Neglect" (1896–1954),[1] African American community leaders were forced into a self-help process where they created their own means of penetrating the healthcare system. Black fraternal organizations, such as the International Order of Twelve Knights and Daughters of Tabor, were essential in the establishment of black operated hospitals in Mississippi. By 1931, nine black hospitals led by fraternal organizations had been created in Arkansas, South Carolina, and Florida. Moses Dickson established the black-owned and operated Taborian Hospital before the *Brown v. Board* decision of 1954, in which racially segregated schools were declared unconstitutional. Dickson was a free African American man and Civil War veteran from Ohio. He had established the African American fraternal organization called the International Order of Twelve Knights and Daughters of Tabor in 1846. Taborian Hospital was founded with $100,000 in funding, used for surgical and laboratory equipment for emergency surgical services along with a blood bank, incubator, and other primary care tools. However, Taborian did not have an ambulance service (Beito 1999, 126). This meant that African Americans had to arrange for their own transportation in order to receive care. Transportation costs thus added another barrier to accessing care during the Jim Crow period. Taborian Hospital was also connected to the larger Civil Rights movement through its practice, as the facility admitted and treated Fannie Lou Hamer, a well-known civil rights advocate, alongside Amzie Moore and other Freedom Ride protesters. Since many other facilities refused African Americans, Taborian Hospital was the first instance of dignified healthcare for Mound Bayou natives. Neglect under Jim Crow was the primary reason why Taborian Hospital and other black-funded hospitals were able to be established and sustained until the Civil Rights Movement. The ideology during Jim Crow was that African Americans were a burden when it came to healthcare, and specific decisions were made as a result of this thinking. For example, white planters did not regulate African American facilities because increased regulations would likely result in the disappearance of these facilities, making African American health a problem for whites to face. Jim Crow laws thus caused the neglect and exploitation of African Americans.

The Friendship Clinic was established in 1948 in the same area as the Taborian Hospital, thus creating a competition for potential African American patients in Mound Bayou. Dr. Theodore Roosevelt Mason Howard, the Chief Surgeon of Meharry Medical College at the time, was the mastermind behind the Clinic's foundation. The Friendship Clinic offered the same ambulatory services on a smaller scale than Taborian. Despite its disadvantage in terms of size, the Friendship Clinic proved to be a rival of Taborian Hospital (Beito 1999, 126). However, both the Taborian Hospital and the Friendship Clinic provided affordable and dignified healthcare services to thousands of indigent African Americans in Mound Bayou.

Financial pressures and regulations eventually caused African American fraternal hospitals in Mississippi to die out during desegregation. These facilities relied on community resource pooling to compensate for the lack of federal funding resources. For example, fraternal members of the Mississippi Jurisdiction of the Knights and Daughters of Tabor raised money through holding spelling bees, beauty contests, and oratorical contests. Some contributors would give

[1] This is the author's terminology from the author's own research, based on her own conceptualization of the period.

goods such as pillows, washcloths, soap, and nonperishable foods instead of money (Beito 1999, 127). This kind of community participation from African American fraternal organizations allowed for medical assistance and care for the members of the financially destitute Mound Bayou community.

Then, in the "Years of Paternalism" (1954–1980s),[2] African Americans were suddenly no longer responsible for their own healthcare. With increasing financial pressures, declining fraternal organization membership, and increased medical regulations, African American hospitals were not able to survive the changing face of American healthcare. Even before desegregation, politicians could sabotage these hospitals through methods involving funding and regulations. Throughout the enforced desegregation process, the federal government became more involved in the operation of formal healthcare provision. Whether or not a hospital could remain in existence was almost entirely up to federal fund allocation and regulations. After the *Simkins v. Cone* case of 1963 and the Civil Rights Act of 1964, African American fraternal hospitals gave way to physician-led community health initiatives. The *Simkins* decision declared that racial discrimination by private institutions, like hospitals, was unconstitutional according to the Fourteenth Amendment (Martin 2016). President Lyndon Johnson signed the Civil Rights Act of 1964, which prohibited discriminatory practices in public facilities. According to the U.S. Department of Health and Human Services, Title VI of the Civil Rights Act of 1964 prohibits discriminatory allocation of federal assistance. One example of a Title VI violation that could apply to the lack of equally-resourced medical facilities in Mississippi is as follows:

> A predominantly minority community is provided lower benefits, fewer services, or is subject to harsher rules than a predominantly non-minority community.

This clause of the Civil Rights Act of 1964 automatically posed Jim Crow in any US facility as unconstitutional. Thus, Jim Crow met its demise in healthcare. Its absence allowed for a greater capacity for activism from both southern and northern medical personnel, rather than just from African Americans themselves. Desegregation helped attract quality care (in comparison to previous years) under the new regulations, such as through Jack Geiger's Tufts-Delta Health Center, the Mound Bayou Community Hospital, and the Medical Committee for Human Rights. Each of these places of care provision allowed for healthcare to be seen holistically as a human right for Mississippians.

The medical needs of black Mississippians were exacerbated by the mechanization of agriculture in the late 1960s. Subsequently, African American residents who could afford to move out of the South to Northern and Midwestern states became part of the Second Great Migration. Meanwhile, back in the Delta, people were without jobs and many did not have enough income to even participate in welfare programs like food stamps. Food stamps required a monthly payment of about 12 dollars for a family of six (Dittmer 2009, 232).

Dr. Jack Geiger, a New York native, was one of the most notable physician-activists who worked in Mound Bayou, Mississippi during the civil rights era. After receiving his medical training at Case Western School of Medicine, Geiger explored the application of his training in international health. More specifically, he worked with Dr. Sidney Kark and Dr. Emily Kark in the Pholela community health center in South Africa in 1958. South Africans were undergoing apartheid, which lasted from 1948 to 1991 and separated black and white people in public

[2] This is the author's terminology from the author's own research, based on her own conceptualization of the period.

facilities, similar to Jim Crow laws in the US. In 1940, the South African Health Department had recruited South African-born Sidney and Emily Kark to establish a community health center in Pholela, a community in KwaZulu-Natal, a rural province in South Africa (Horwitz 2009, 3–6). The Karks' health activism helped establish a community health center for the Pholela community that focused on preventive care, health promotion, and training community health workers. The Pholela community center was modeled such that the community would have the tools it needed to deliver health education and environmental interventions (Dittmer 2013, 29–30).

In gaining information about Mississippi during the civil rights movement, Geiger identified health needs similar to those he had observed in Pholela, and decided to then bring this South African community model of care to the United States. Inspired by this work in South Africa, Geiger recruited Dr. Count Gibson, a Georgian, to work with him on bringing the community health model to the US. In his 2013 interview with John Dittmer, Geiger recalled the moment he shared his inspiration during a Delta ministry meeting:

> For the first time in this whole sequence, I *remembered Pholela* and the community health centers in South Africa and kind of blurted out, "What really needs to happen is that a good Northern medical school should come down here and start a comprehensive community health center."
>
> And everybody said, kind of, "What is that?" And I described it, this concept of care for the individual and care for community, the integration of clinical medicine and public health, and the attention, indeed, to the environment, but also to the social and political and economic environment. (Dittmer 2013, 40; emphasis original).

Geiger's experiences in South Africa would change the systemic operation of healthcare in the United States, especially for predominantly black, rural, and low-income regions of the South. His holistic perception of health, gleaned from his experience in South Africa, stemmed from the idea that health is a human right ("H. Jack Geiger, Oral History Interview," 1992). In order to deliver care without regard for a patient's socially ascribed status, the caregiver must believe that health is not a commodity but a civil right. Geiger implemented this idea of health as a civil right when founding the Tufts-Delta Health Center with Dr. Count Gibson in 1965. In the process of securing funding from the Office of Economic Opportunity (OEO), Geiger noted that the health of participants in the OEO's anti-poverty programs, Head Start and Job Corps, was suboptimal. With Geiger's support, the Tufts-Delta Health Center was the first health component that the OEO funded ("H. Jack Geiger, Oral History Interview," 1992). Geiger was fueling a change in terms of medical infrastructure in Mississippi, setting up medical care that had not previously been in place, even with the creation of Taborian Hospital. The Tufts-Delta Health Center formally began clinical work in the fall of 1967. However, they ran into the same problem that the African American population in the area had previously experienced, the lack of willing physicians. In a 1988 letter to L.C. Dorsey, a known health activist, Geiger explained the physician recruitment problem in rural Mound Bayou:

> The problems faced by physicians in rural areas and in practices like the Delta Health Center include: social and intellectual isolation, professional isolation and limitation (inability to conduct hospital practice, limited number of colleagues and consultants); amenities; educational facilities for children; job opportunities for spouses (Jack Geiger Collection, Folder 82).

Dr. Geiger recruited mostly pediatricians due to the population skew of Mound Bayou. In his 2013 interview with Dittmer, he noted that the median age was 15 and "the median age of male heads of households was 50," and that those in between the two ages were part of the Second Great Migration from about 1940 to 1970 (Dittmer 2013, 63). The population that would have balanced out the skewed statistics left the South to obtain better paying industrial jobs in Chicago and other northern cities. Geiger perfectly stated in the aforementioned quote why physicians at large were not drawn to practicing in rural, low-income areas such as Mound Bayou. Jim Crow laws significantly narrowed the scope of practice for African American physicians until the civil rights-based win in the *Simkins v. Cone* case of 1963, which declared any discrimination toward black doctors in practice settings unconstitutional.

In 1966, John W. Hatch called the quality of care offered by Taborian Hospital "awful," given its outdated technology and lack of focus on preventive care such as immunizations (Beito 1999, 129). In comparison to Taborian Hospital, Tufts-Delta Health Center (TDHC) had more resources and could do much more than provide clinical care for the all-black town. TDHC provided services that addressed the underlying determinants of health such as environmental, social, and economic factors, using health education (Jack Geiger Collection, Box 4, Folder 92). This is evidence of Geiger's approach to health as a human right. Patient illnesses in Mound Bayou could not be properly addressed without addressing shelter, food sources, and health information. In fact, in 1980, the Tufts-Delta Health Center's work in Mound Bayou sparked political support from Alpha Kappa Alpha Sorority, Incorporated, a black Greek organization Alpha Kappa Alpha Sorority, Inc. n.d.).

The Medical Committee for Human Rights (MCHR) was founded in 1964 with Dr. Jack Geiger as one of the founding members. The MCHR provided care for civil rights activists and newly desegregated hospitals, and also became involved in the civil rights movement on a larger scale. The MCHR protested the American Medical Association's denial of membership to black physicians. The organization also recruited nurses, social workers, physicians, and other medical personnel to send into areas without adequate medical manpower. The organization was mostly founded by physicians of Jewish descent, although the first three chairpersons of the organization were black (Dittmer 2009, xi).

Though it was not specifically involved in ensuring better health conditions for Mound Bayou natives, the MCHR was involved in healthcare activism around the time of Mississippi's Freedom Summer of 1964. The MCHR had arrived in Mississippi without resources such as personnel or updated technology, but it provided the manpower and community leaders to organize healthcare for Mississippians during this time. Moreover, organization members experienced the coldness of white supremacy and Jim Crow laws as they attempted to activate white physicians in the civil rights fight for healthcare. This is most apparent in the aftermath of the "Brenner-Coles Letter," in which the MCHR attempted to rally white physicians to provide care for poor Mississippians. As noted in *The Good Doctors,* the tone of the "Brenner-Coles Letter" was received as a condescending one, and it alienated even more moderate and cooperative white physicians and kept them from potentially participating in the civil rights cause (Dittmer 2009, 40–41).

In *The Good Doctors*, Dittmer notes that another barrier for the MCHR was the difference in MCHR's meaning to the enrollees. After Mississippi's Freedom Summer of 1964, the MCHR was left with two factions: the civil rights and public health factions. The civil rights faction wanted doctors to lend their bodies, not their political power, to fuel the civil rights struggle for healthcare. This meant that these MCHR participants expected physicians to show up to protests

and be physically involved in grassroots struggles. Tom Levin, a primary catalyst for the MCHR, was a part of the civil rights faction that was created once the MCHR left Mississippi. He wanted doctors to lay down their bodies to fight for the greater cause (Dittmer 2009, 40–41). Geiger also mentioned the differences in purposes for joining the MCHR in his 2013 interview with Dittmer. He stated that, on one hand, some individuals came with the clear purpose of partaking in public health interventions as medical professionals. On the other hand, Geiger noted, some people who were involved *appeared* to have similar reasons for joining but their actions showed otherwise. Individuals that fell into this category did not want to live among the black community like the other participants (Dittmer 2013, 34–35). In separating themselves from the community to enjoy a more cushy lifestyle, their motives for joining the MCHR seemed to be more for show, rather than out of a genuine care for understanding Mississippi's healthcare complexities.

A struggle aside from the covert differences in ideologies was the lack of organization. The first set of MCHR volunteers did not have guidance or instruction. They simply had to figure out their role as they went along (Dittmer 2009, 48). The MCHR volunteers went to tour the Mississippi facilities and build relationships with the existing black practitioners, but were met with the coldness of Jim Crow. The few black physicians that practiced in the state were middle-aged and conservative for the most part. These black doctors did not want to threaten their prized medical career by being involved in the civil rights movement, and thus very few of them would provide care for civil rights activists before desegregation (Dittmer 2009, 45). For instance, Dr. Aaron Jackson would not provide medical care to a civil rights activist who was beaten in Greenwood, Mississippi, even though he was the only black doctor in the town (Dittmer 2009, 45).

In 1967, Sarah Brown Hospital and Taborian Hospital buildings merged to create the Mound Bayou Community Hospital, the only volunteer hospital between Greenville and Memphis ("Forming a New Board," 1967). According to David Beito's "Black Fraternal Hospitals in the Mississippi Delta," community members would recall Taborian's care in a more positive light in the 1950s and 1960s than what Geiger and Hatch saw in the facility when they arrived in Mississippi. During the 1970s and 1980s, after the Taborian and Sarah Brown Hospitals merged to create Mound Bayou Community Hospital, perspectives of the care seemed to neutralize. Granted, this was after federal regulations had been imposed on Mississippi's healthcare system. Before Mound Bayou Community Hospital came into existence, Taborian Hospital was unique to residents in Mound Bayou. The patients did not have access to these kinds of services during Jim Crow.

Mississippi epitomizes the white supremacist and inhumane processes that led to the legendary deaths of Dr. Charles R. Drew and Juliette Derricotte. Until the passage of the civil rights acts of the late 1960s, African Americans were forced to find ways to provide their own healthcare, a necessity that was clearly against the 1948 Universal Declaration of Human Rights and the WHO's 1948 Constitution. Similar to the educational desegregation process, the increase in regulations geared toward anti-discriminatory practices decreased both the autonomy and neglect that these communities had previously been forced into, while also increasing government role in healthcare provision. In this way, health care activism evolved from a more direct community approach to a more physician-driven one with the increase of regulations. Black-owned medical facilities could not survive the financial and regulatory pressures of the desegregated healthcare system. Even though these hospitals could not bear the systemic pressures and lacked resources for quality care provision, they had provided medical safe havens from the mainstream Jim Crow atmosphere. These were trustworthy facilities where black

people could maintain their health with their dignity intact. These facilities should thus be viewed as a success for the black community during a time of medical segregation.

The Medical Committee for Human Rights, Tufts-Delta Health Center, and the Mound Bayou Community Hospital later served as formal and quasi-formal means of delivering healthcare to destitute populations of Mississippi. These organizations and facilities maintained that care should be provided without regard to nationality, creed, race, gender, age, or socioeconomic status. Geiger's community health center further employed the health as a human right ideology, and black fraternal hospitals fought against the idea that black people did not deserve healthcare services. Jim Crow fueled the idea that health is a commodity and a right that can be granted to those considered to be deserving and denied to those seen as undesirable. The community health center sparked a continuation of the same ideologies that had previously forced the establishment of black fraternal hospitals. With the increase of community health centers, health was not approached only as a matter of illness, but as a symptom of poverty, lack of shelter, lack of financial resources, and lack of information. Thus, health activism actors such as physician-activists (like Dr. Jack Geiger), the Medical Committee for Human Rights, Taborian Hospital, Mound Bayou Community Hospital, and the like exemplify the changes in approaches to healthcare as a human right, before, during, and after the desegregation process.

References

Alpha Kappa Alpha Sorority, Inc. "Centennial Celebration. 1908–2008: Service to All Mankind. National Programs." http://aka1908.com/centennial/pdf/programs_pdf.pdf.

Beito, David. 2000. "Black Fraternal Hospitals in the Mississippi Delta." *From Mutual Aid to the Welfare State: Fraternal Societies and Social Services, 1890-1967*. Chapel Hill: The University of North Carolina Press.

Beito, David. 2000. "Our Temple of Health." *From Mutual Aid to the Welfare State: Fraternal Societies and Social Services, 1890-1967*. Chapel Hill: The University of North Carolina Press.

Civil Rights Requirements. Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et. Seq. ("Title VI").

Gale Research. 2002. "Derricotte, Juliette (1897–1931)." Women in World History: A Biographical Encyclopedia. *Encyclopedia.com*. http://www.encyclopedia.com/women/encyclopedias-almanacs-transcripts-and-maps/derricotte-juliette-1897-1931.

Dittmer, John. 2009. "The Medical Arm of the Civil Rights Movement." *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care*, 61–84. New York: Bloomsbury Press.

Dittmer, John. 2013. H. Jack Geiger oral history interview. Conducted by John Dittmer in New York, New York, March 16. Transcript. https://cdn.loc.gov/service/afc/afc2010039/afc2010039_crhp0076_Geiger_transcript/afc2010039_crhp0076_Geiger_transcript.pdf.

Flowers, Nancy, ed. 1998. "A Short History of Human Rights." In *Human Rights Here and Now: Celebrating the Universal Declaration of Human Rights*. Human Rights Educators' Network. Amnesty International. http://hrlibrary.umn.edu/edumat/hreduseries/hereandnow/Part-1/short-history.htm.

Horwitz, Simonne. 2009. *Health and Health Care under Apartheid*. Adler Museum Bulletin. https://www.wits.ac.za/media/migration/files/cs-38933-fix/migrated-pdf/pdfs-4/health%20and%20health%20care.pdf.

Kruse Thomas, Karen. 2006. "Simkins v. Cone." https://www.ncpedia.org/simkins-v-cone.

Love, Spencie. 1997. *One Blood: The Death and Resurrection of Charles R. Drew*. Chapel Hill: University of North Carolina Press.

Martin, Jonathan. 2016. "Simkins v. Cone (1963)." North Carolina History Project. http://northcarolinahistory.org/encyclopedia/simkins-v-cone-1963/.

Office for Civil Rights (OCR). July 26, 2013. "Civil Rights Requirements: Title VI of the Civil Rights Act." HHS.gov.

Ridlon, Florence. 2005. *A Black Physician's Struggle for Civil Rights: Edward C. Mazique*. University of New Mexico Press.

United Nations. 1948. Universal Declaration of Human Rights. http://www.un.org/en/universal-declaration-human-rights/.

"What is the Difference Between a Human Right and a Civil Right?" n.d. HG Legal Resources. https://www.hg.org/article.asp?id=31546.

Ward, Thomas J. 2016. *Out in the Rural: A Mississippi Health Center and Its War on Poverty*. New York: Oxford University Press.

World Health Organization (WHO). 2018. "About WHO. Constitution of WHO: Principles." http://www.who.int/about/mission/en/.

Archival Sources

"Alpha Kappa Alpha, 1980-1981." Box 1. Jack Geiger Collection on the Delta Health Center 5699, Southern Historical Collection, The Wilson Library. The University of North Carolina at Chapel Hill.

"Health of the Poor a 'National Disaster." 1968. *The New York Times.* May 19, 1968. "Clippings, 1960s." Folder 319. Jack Geiger Collection on the Delta Health Center 5699, Southern Historical Collection, The Wilson Library, the University of North Carolina at Chapel Hill.

"Forming a New Board." 1967. Box 5, Folder 105 in the Jack Geiger Collection on the Delta Health Center 5699, Southern Historical Collection, The Wilson Library, the University of North Carolina at Chapel Hill.

"H. Jack Geiger, Oral History Interview." 1992. Conducted by Robert Korstad. Jack Geiger Collection on the Delta Health Center 5699. Southern Historical Collection. The Wilson Library. the University of North Carolina at Chapel Hill.

Jack Geiger Collection on the Delta Health Center 5699. Southern Historical Collection. The Wilson Library, the University of North Carolina at Chapel Hill.

Lyons, Richard D. 1968. "Hunger and Sickness Afflict Mississippi Negro Children." Newspaper clipping from *The New York Times* issue on Monday, March 25, 1968. Folder 216. Geiger Collection on the Delta Health Center 5699, Southern Historical Collection, The Wilson Library, the University of North Carolina at Chapel Hill.

"Physician Recruitment, 1972-1993." A Letter to L.C. Dorsey, November 28, 1988. Folder 82. Jack Geiger Collection on Delta Health center 5699, Southern Historical Collection, The Wilson Library, the University of North Carolina at Chapel Hill.

"Wait and See Treatment." 1967. Newspaper clipping from *The Boston Globe*. Monday, July 17, 1967. Folder 320. 'Clippings, 1960s.' Jack Geiger Collection on the Delta Health Center 5699, Southern Historical Collection, The Wilson Library, the University of North Carolina at Chapel Hill.

"Water Crisis 1969." Box 1. Jack Geiger Collection on the Delta Health Center 5699, Southern Historical Collection, The Wilson Library, the University of North Carolina at Chapel Hill.