REPORT
ON
NEW YORK CITY:
HEALTH FACILITIES

BY THE
NEW YORK STATE ADVISORY
COMMITTEE TO THE
UNITED STATES COMMISSION
ON CIVIL RIGHTS

MAY 1964

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NEW YORK STATE ADVISORY COMMITTEE

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Preface

This report was submitted to the United States Commission on Civil Rights by the New York State Advisory Committee. The New York State Advisory Committee is one of the 51 Committees established in every State and the District of Columbia by the Commission pursuant to section 105(c) of the Civil Rights Act of 1957. Its membership consists of interested citizens of standing who serve without compensation. Among the functions and responsibilities of the State Advisory Committees, under their mandate from the Commission on Civil Rights, are the following: (1) to advise the Commission of all information concerning legal developments constituting a denial of equal protection of the laws under the Constitution; (2) to advise the Commission as to the effect of the laws and policies of the Federal Government with respect to equal protection of the laws under the Constitution; and (3) to advise the Commission upon matters of mutual concern in the preparation of its final report. The Commission, in turn, has been charged by the Congress to investigate allegations, made in writing and under oath, that citizens are being deprived of the right to vote by reason of color, race, religion, or national origin; to study and collect information regarding legal developments constituting a denial of equal protection of the laws; to appraise Federal laws and policies with respect to equal protection; and to report to the President and to the Congress its activities, findings, and recommendations.

Contents

Introduction

This is a report on a study made in New York City between February and June 1963 to assess the extent to which Negroes are experiencing equality with whites in the study and practice of medicine and its related fields. It was undertaken by the New York State Advisory Committee at the request of the U.S. Commission on Civil Rights and forms an integral part of a nationwide survey on the subject being made for the Commission by its Advisory Committees. This study was conducted by a Special Committee whose members were appointed by the New York State Advisory Committee. It was pursued through a questionnaire prepared by the Special Committee and distributed to all municipal and voluntary hospitals in New York City. This was followed by interviews and correspondence with persons in the field who were both available and representative.

Various limitations to the scope of this report must be noted. The size of the problem and the intricate nature of the New York City medical structure demanded more time than was available; in some hospitals resistance was encountered and results of concurrent studies could not be obtained; unfamiliarity with the clearance policy of the Greater New York Hospital Association caused certain delays and omissions.

The New York State Advisory Committee wishes to acknowledge the cooperation of the Special Committee of physicians and laymen whose members gave arduous and devoted efforts to the fulfillment of their assignment.

Number of Negro Physicians in New York City

The National Medical Association records slightly more than 5,000 Negro physicians in the United States, of whom less than 500 are located in New York City. The ratio of physicians to population in the city in 1956 was 1 to 2,754 for Negroes and 1 to 480 for whites, according to figures compiled by Dietrich Reitzes.[1] Since that time, the Negro population of the city has increased markedly just as the Negro percentage of the city's population has risen sharply.

Dr. Peter Murray,[2] a member of the Special Committee that conducted this survey, has stated that the current rate of entry of Negroes into the medical profession is not sufficient to replace those who die or retire. Thus any steps taken to improve the opportunities for Negro physicians in New York City must be accompanied by steps to increase the supply of those able to take advantage of these improvements.

Medical educators recognize the urgent need to increase the number of Negro physicians in the country. The following statement by Dr. S. Bernard Wortis, dean of the New York University College of Medicine, in response to the questionnaire, is indicative:

> In order to balance opportunity for Americans today, other things being equal, I would favor a Negro medical student applicant if he were equally qualified with a white man.

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1. Negroes in Medicine by Dietrich Reitzes published for The Commonwealth Fund by Harvard University Press, Cambridge, 1958, 400 pp.

2. Former president of the New York County Medical Society and former president of the Medical Board of Sydenham Hospital.

Hospitals

Internships and Residencies

Selection of interns at most hospitals is made through the National Intern Matching Program. Cooperating hospitals send in the number of interns needed and state their preferences which are based upon applications and interviews with candidates. They also list the applicants whom they will not accept. Prospective interns send to the Program a list of hospitals in order of preference. An IBM machine does the mechanical matching job. The result is that the top hospitals get the men they want and the top men get the hospitals they want but thereafter the process is not so successful. In 1962, 12,705 internships were to be filled by the matching plan and 6,748 were matched. This indicates that the need for interns far exceeded the supply. While the IBM machine has an inherent objectivity, it also has an inherent inability to determine whether a participating hospital has listed as acceptable only candidates who are known to be white.

While the Negro who was graduated from medical school in the 1920's was likely to find internship and residence opportunities only in Negro hospitals, the picture has been substantially altered today. By 1963, 68 percent of Howard and Meharry Medical school graduates were interning in non-Negro hospitals. Negro graduates of predominantly white medical schools showed an even higher percentage of internship in white hospitals. Leading hospitals show a scarcity of Negro interns but there is no evidence that the scarcity is based on anything other than the number of qualified Negro applicants. If for no other reason, the continuing shortage of interns and residents would seem to confirm the opinion of medical institutions that any qualified Negro can secure good post-graduate training as an intern or resident.

Staff Positions

The most critical problem facing the Negro physician in New York City is that of securing an appointment to a hospital staff that carries admitting privileges for his patients with it. Appointments to the outpatient clinic staff are obtainable. Appointments to the attending staff are a quite different matter. This often applies even to those Negro physicians who have served as interns or residents of a given hospital and have been on its outpatient staff. When this happens, the physician must either admit his private patient to another hospital where he has such privileges, or he must ask a white colleague to use his admitting privileges for the patient.

Of the 4,004 doctors with admitting privileges reported by those hospitals which responded to the questionnaire and by physicians who were consulted, 70, or 1-3/4 percent, were Negroes. Of the 3,271 physicians who were reported to have active staff status, 57 or approximately the same percentage were Negroes. According to figures obtained by the Special Committee, from National Medical Fellowships[3] Negro physicians constitute 2.2 percent of the total medical profession in New York City.

Basic requirements for attending staff appointments, especially those for the highly visible hospitals, include board certification and a commitment on the part of the physician to give uncompensated time on the wards and in the outpatient services. Actually, however, since many staff appointments precede board certification, standards are flexible and can be subjective. The Negro physician, at the end of many years of costly schooling, may not be able to afford the necessary extra time for board certification and, thus, may be automatically barred from consideration for a staff appointment with admitting privileges.

Decisions on staff appointments are private, made either by a small, intimate group, or by the single individual who is the head of the service at a given hospital. In many ways, being on the staff is being "in the club". It confers status, economic benefits, and a measure of long term security.[4]

Although the essentially anonymous process of selecting physicians for hospital staff appointments was not designed to facilitate discrimination, it does enable a head of service to practice it with impunity if he wishes. This survey drew responses from Negro physicians who cited several hospitals in which they felt prejudice was excluding Negroes from staff positions. Every hospital, especially a private voluntary hospital, tends to have a distinctive character, tradition, and mode of procedure. Set patterns of this kind make it difficult to review past practices that may have involved discrimination. In some hospitals, appointments to high staff positions have an almost hereditary character,

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3. Opportunities for Negroes in Medicine, National Medical Fellowships, Inc., Chicago, 1959, 22 pp.

4. Analagous benefits are conferred by admission to the various building trade unions which the New York State Advisory Committee has also studied. The admission process in both cases is well screened from public view. Any effort to make more public and objective the standards for admission to hospital staffs would undoubtedly produce an even more heated response than that which greeted similar proposals concerning the building trades unions.

deeply affected by habits of relationship with certain families and schools. In such hospitals, the admission of the Negro physician as an attending staff member requires the transformation of more than racial patterns.

Negro physicians report that while opportunities for Negro residents and interns have increased in the last 25 years, the factors that influence staff appointments have changed very little. Where Negro staff participation does exist, they note that it is often on a token basis with an unusually high incidence of women anesthetists and pediatricians.

Despite these limitations to hospital staff membership, New York is in the vanguard of States which are working toward non-discriminatory hospital policies. In 1963, in the first action of this kind by a State Legislature known to the Committee, the New York State Legislature authorized the State's Welfare Board to order medical institutions in the State to permit any duly licensed physician to practice in the institutions when it appears after investigation that the individual has been discriminated against because of his color or race.[5]

Opportunities For Practice

Institutional, Referrals, and Employment

A doctor whose name is on an insurance company's referral list has a steady source of income from persons referred to him by the company for diagnosis, examination, and, in certain cases, treatment. Payments per session from the insurance companies are not very high and few physicians would want to do this work exclusively. However, most of the companies limit their lists in order to keep the referring doctors fairly busy and such referrals are a helpful source of income.

Life insurance companies ordinarily use general practitioners and internists since the applicant for insurance often must be given a physical examination in order to qualify for a policy. The opportunity for Negro physicians in this area does not seem to be limited on the ground of race. Casualty companies generally use specialists since the examination usually takes place after an accident and workmen's compensation proceedings or negligence litigation may be involved. In such cases impressive hospital staff affiliations are valuable as the doctor is often called to testify as an expert witness.

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5. Chapter 913 of the 1963 Acts of the New York Legislature.

For reasons indicated in the preceding discussion of hospital staff affiliations, Negroes are seldom found on the referral panels used by casualty companies. There are a very few exceptions, which may indicate that race per se is not a substantial factor in accounting for the small number of Negro physicians on referral lists of casualty companies.

A physician becomes enrolled on a referral panel through various procedures of which the most common is an application for listing by the physician himself. The best evidence of discrimination would therefore be a refusal by an insurance company to accept an application from a qualified Negro physician. Within the limitations of this survey, no such evidence is shown.

HIP (Health Insurance Plan) medical groups provide at least one example of completely integrated medical practice. The plan consists of 32 separate, autonomous partnerships of physicians under contract with HIP in accordance with its policy. While HIP does not organize the groups of physicians, it has an explicit policy of encouraging interracial medical and patient groups. Of 31 groups of physicians in the New York City and Nassau areas, more than one-third are interracial medical groups. HIP has thus helped to provide many Negro physicians increased opportunity to practice medicine utilizing their special competence, and has helped countless patients, both Negro and white, to secure excellent medical care.

Very few Negro physicians are doing research, whether sponsored by academic institutions, foundations, or agencies concerned with a specific disease.[6] In this area the Committee found no evidence of discrimination against Negro physicians or students.

Medical Schools

The number of Negro students attending American medical schools is decreasing. The following figures show the attendance of Negroes at medical schools, other than Howard University and Meharry Medical College, in the years given:

Years	Attendance
1947-48	93
1956-57	216
1961-62	164

6. A large number of physicians of Asian ancestry was found to be engaged in research in the New York City area.

New York City medical schools reflect the recent decline. In 1956-57, 19 Negroes were attending medical school in the city as compared to 17 in 1961-62.

New York State has a Fair Educational Practices Act administered by the State Department of Education. Theron Johnson[7] of the State Education Department studied applications, interviews, and other admissions practices at Downstate Medical Center to determine the extent of the Center's compliance with State policy. Mr. Johnson's study found no evidence of discrimination. The Special Committee knows of no study of any medical school in the city which has reached a different conclusion.

Admission to the leading medical schools in the city is a highly competitive process. The ratio of admissions to applications for 1962 has been estimated by New York University as 127 out of 1,800 and at the College of Physicians and Surgeons at Columbia University as 120 out of between 1,200 and 1,300. The Nation as a whole is faced with a shortage of doctors and medical students, and within this situation, there are very few Negro doctors and extremely few Negro medical students. While the best medical schools can demand first rate college students, other medical schools accept students with average college records. Negro students with "average" college records are almost never found in medical schools.

"Opportunities for Negroes in Medicine",[8] published by National Medical Fellowships, Inc., which grants funds to Negro students and doctors, estimates that 25 medical schools that had no Negro students in 1955-56 would have accepted qualified applicants. This publication also expresses the view that by 1958 the qualified Negro applicant had opportunities for acceptance in a first rate medical school commensurate with those of qualified white applicants. The following comment of Dr. George Perera, Associate Dean of the College of Physicians and Surgeons at Columbia University, illustrates this:

> There are two Negro applicants for this year's freshman class. P & S found one unacceptable and was very eager to enroll the other. However, he obtained from another school a scholarship twice as large, and there are no American Negroes in this year's class.

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7. Administrator, Education Practices Act, the State Education Department, the University of the State of New York.
8. Opportunities for Negroes in Medicine, National Medical Fellowships, Inc., Chicago, 1959, 22 pp.

The Medical College aptitude test is widely used by medical schools. While the test is "objective", it clearly favors those with precise language skills, a sound cultural background, and a good undergraduate education. The young Negro expecting to be a physician must acquire the skills that this type of test demands. It is the consensus among medical school administrators that when he has acquired these skills and has obtained admission, lack of funds will not handicap his medical education. National Medical Fellowships reports that it has available more scholarship funds than applicants to use them.

This study suggests that early and well-informed counseling may well be the decisive factor that leads a Negro to or away from medicine. This counseling must begin far earlier than the college level in order to play a useful role in selection of school and career. Dr. George D. Cannon, a member of the Special Committee for this survey, reaching back to find the point at which the Negro begins to be lost to medicine, observes that high school guidance counselors automatically direct Negroes into vocational courses. The result, as he says, is that "even if they want to go to college, they find they haven't the credits."

The following statement to the Committee by Mrs. Hilde Reitzes, executive secretary of National Medical Fellowships, Inc., concurs with the findings of the current study:

> In our experience of screening applications for scholarships to attend medical school, we have been concerned for many years with the problems of inadequate preparation in college, high school, elementary school, and even before then in the home, on the part of the Negro. This shortcoming, regardless of any discrimination that may exist in medical school, seems to be the major problem that Negroes have to overcome in getting admitted to medical school.

Nurses And Nursing Schools

Career opportunities for Negro nurses and Negro students who wish to enter nursing are far wider than they were twenty years ago in New York City. In 1941-42, practically no Negro nurses were to be found in voluntary hospitals. Negro applicants were almost unknown in nursing schools in New York City except in Harlem Hospital Nursing School, a public municipal school, where they were sent from other municipal nursing schools, and in Lincoln Hospital, which is now a municipal institution but was then a voluntary hospital. It

was assumed that semiprivate and private patients would not "submit" to care by Negro nurses. While some patients still have this attitude, it represents only a personal feeling and has no relation to hospital policy.

Confronted with a nationwide shortage of nurses, municipal hospitals, and subsequently other nurse training institutions, began to remove racial barriers during World War II. The need for nurses is so urgent that, in most cases, professional criteria are the only ones applied. Perhaps as a carryover from earlier practices, the percentage of Negro nurses remains considerably higher in municipal hospitals than in voluntary hospitals.

Miss Norma Owens, R.N., a member of the faculty of the School of Education at New York University, who teaches graduate nurses, notes a substantial decrease in the number of Negro high school graduates who have entered nurse training programs in the last two or three years. The number has not kept proportionate pace with the number of Negro girls who are being graduated from high school nor with the greatly increased opportunities to be found in nursing. Previously, Miss Owens explains, these girls had had only the choice of nursing or teaching open to them as professional possibilities.

Miss Owens reports that a substantial percentage of her graduate students are Negroes who are taking courses to meet the requirements for advanced placement. Some are already supervisors. Most of her students are hospital nurses, but some work in schools, industry, and elsewhere. The Negroes are evenly distributed among the various places of work and express to her no dissatisfaction with their progress.

Mrs. Olga Fessenden of the New York Counties Registered Nurses Association reports that the Lincoln School of Nursing, which was set up to accept Negroes who were not admitted elsewhere, has been dissolved because the need for it is gone. Similarly, the National Negro Nursing Association was disbanded in 1951 and its membership was absorbed into the American Nurses Association. This organization recently discontinued its intergroup division because it, too, was no longer needed. Mrs. Fessenden says the Counties Association would take cognizance of complaints but never receives any.

About half of the nursing students at Bronx Community College and 123 out of the 126 students at Harlem Hospital last year were Negroes. Of the other ten institutions responding to the survey, some had a scattering of Negroes in their student bodies and some had none. Generally speaking, it can be said that a number of Negro girls are studying nursing but not in the same schools as the white girls. Almost half of the institutions responding to the survey

expressed reservations to some degree about the qualifications of Negro applicants. Clearly, these girls have not had the benefit of a high school education commensurate with that of the white girls with whom they compete for entrance. The number of reports which indicate that applicants lacked required credits once more underlines the urgency of adequate and imaginative high school counseling. On the basis of this survey it would appear that nursing and nurse training are as free from discrimination on the ground of race or color as any career opportunity that exists in the city.

Medical Care

In New York City in 1960, life expectancy for white males was 67.3; for nonwhites, 60.8; for white females, 73.1; for nonwhite females, 67.6. The total average infant mortality rate per 1,000 live births in 1961 was 25.6; for nonwhites alone it was 39.7. Infant mortality rates in a central Harlem district were 45.2 per 1,000, nearly double the total average. Deaths from all causes in New York City averaged 11.2 per 1,000; in the same central Harlem district they were 13.4.[9] These figures seem to say that the right to life itself is affected by color.

Some Negro families pay for and receive the best medical care in the city. Whether they use white or Negro physicians, they have access to semiprivate and private facilities in superior hospitals. In many of the leading hospitals the wards are occupied chiefly by Negro patients who, however little their means, are treated by physicians of the highest competence. One of the city's most respected hospitals reports that distribution of Negro patients is as follows:

Wards	-	80 percent
Semiprivate rooms	-	12 percent
Private rooms	-	3 percent

These statistics raise rather than answer questions as to the relation between medical care and Negro life expectancy. They invite further questions as to whether differing levels of medical care are due to direct discrimination or to cultural or economic factors resulting from a broad pattern of discrimination. For example, many Negro families may delay calling a doctor because they lack education or financial resources. The assumption on the part of medical personnel that Negro patients have little or no money to pay doctor's fees may result in less attention to medical

9. Summary of Vital Statistics 1961, The City of New York. Department of Health, the City of New York, 12 pp.

needs. The Negro patient who goes to a Negro physician may find his admission to a hospital complicated and postponed because his physician has no admitting privileges.

It is estimated by reliable medical authorities in the city that Negroes and Puerto Ricans constitute a high and increasing percentage of those belonging to Blue Cross, but more than half of the nonwhite participants in Blue Cross do not use semiprivate facilities although they are entitled to them. This may be due to ignorance of their rights, lack of money to pay doctor bills, or the fact that their physicians cannot get them into hospitals as semiprivate patients because the physicians lack admitting privileges and must send patients through the clinics and into the wards.

No hospital administrator in response to the Committee's questionnaire or in discussion of the subject in an interview reported any difference in the admission or treatment of white or Negro patients. Whether in clinics or wards or semiprivate or private facilities, all reported that their hospitals did not discriminate or segregate. However, none mentioned a written policy on nonsegregation nor was personnel specifically instructed not to segregate the patients. The consistent answer given to this question was that a formal policy statement to this effect was not necessary.

Although all hospitals claim to admit patients and assign them beds and afford them medical care without discrimination or segregation, a number of physicians assert that there are hospitals which do group patients by color. One white physician, who has a high post in a leading voluntary hospital, says, "There's no doubt that voluntary hospitals frequently find that they 'have no bed available' when a Negro patient wants to be admitted--except when the patient has a condition of special interest medically."

This discrimination on admission or bed assignment has sometimes been found to be the reflection of personal attitudes in the admissions office or the receiving floor. Discrimination of another kind may also be inherent in the medical structure of the hospitals whose patients are primarily Negroes. One physician suggests that because some of these hospitals have poor facilities, no research is done in them and so they attract only second rate house staffs. He concludes that in such hospitals the patients are not getting really good medical care. While this is but the observation of a single physician, it indicates one way in which larger patterns of

past and present discrimination may be related to differing levels of medical care and perhaps even to sharply differing vital statistics. The City Commissioner of Hospitals is known to deplore the low standards of professional and routine care given by staffs in unaccredited hospitals.

The following excerpt from Herbert Klarman's "Hospital Care in New York City"[10] makes clear that health insurance does not blot out all distinctions among hospital patients:

> A study of patients in a group of nine voluntary general hospitals found wide variations among the three ethnic groups in the proportion of patients with Blue Cross insurance who used the ward. Among non-Puerto Rican white patients with Blue Cross 10 to 15 percent use the ward; among nonwhites the proportion exceeds 50 percent; and among Puerto Ricans, it reaches 70 percent.

We are left with evidence of a clear correlation between ethnic background and the type of hospital facility that is used. We are also left with the conclusion that, apart from some instances of segregated patient placement, Negro patients in New York City receive nondiscriminatory attention. Insofar as the level of care they receive is lower than that given white patients, this is probably a reflection of larger patterns of discrimination within the community.

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10. Hospital Care in New York City by Herbert Klarman, Columbia University Press, New York and London, 1963, 575 pp.

Conclusions

1. A general shortage of physicians and medical students exists throughout the Nation. Despite increasingly broadening opportunities in the past twenty-five years, an acute shortage of Negro physicians and medical students is apparent. The ratio of physicians to population in New York City in 1956 was 1 to 480 for whites and 1 to 2,754 for Negroes.

2. The current rate of entry of Negroes into the medical profession is not sufficient to replace the Negro physicians who die or retire. With the rapid growth of the Negro population, the paucity of Negro physicians is becoming more acute. The achievement of a greater role for the Negro in the medical profession in the city depends more upon imaginative programs to recruit qualified Negroes to medicine than upon altering the practices of hospitals and other medical institutions.

3. While there is a superabundance of applicants for internships and residencies at leading hospitals, there are insufficient interns and residents to fill more than half of the total national need. Partly because of this shortage, Negroes are no longer relegated to Harlem Hospital for internships and residencies as they were 25 years ago. Today vestiges of discrimination remain but many Negro interns and residents find positions commensurate with their qualifications.

4. The Negro physician has less opportunity for appointment to a hospital staff position than his white colleague. While, in some instances, this may be due to economic factors which limit his ability to pursue studies necessary for board certification or to devote sufficient hours to ward or clinic work, the probability cannot be overlooked that racial discrimination is a factor in this situation. In some of the voluntary hospitals, staff appointments are bound up with exclusive family and academic traditions, and in nearly all hospitals, appointments are made by the head of a given service. If the head of service chooses to practice discrimination in staff appointments, no practical means are at hand to change his policy.

5. The effects of restricting appointments of Negro physicians to hospital staffs are numerous and serious. The physician is deprived of the prestige, economic benefit, and opportunity to practice the quality of medicine that staff appointments provide. His patients cannot be admitted to the better hospitals as his patients. The community in general, medical students, seriously ill patients, and others who come in direct contact with staff physicians are substantially deprived of the fullest development of the talents of the city's Negro physicians.

6. The Negro physician's opportunities either for full time employment or referrals from insurance companies, utility firms, and related industries do not seem to be limited on grounds of race. The Committee knows of no evidence that the relatively small number of Negroes employed in research or in other institution-supported medical activity is traceable to discriminatory practices.

7. The small number of Negro physicians in the city affords an all-too-ready answer to inferences of discrimination that may be drawn concerning medical institutions found to employ no Negroes or few Negroes. However, there is evidence that an affirmative interracial policy can produce different results from the same supply of Negro physicians. HIP has deliberately welcomed, but has not created, interracial medical and patient groups. As a result, more than 1/3 of the 32 autonomous partnerships of physicians under contract to HIP are interracial.

8. In the city, as in the Nation, the number of Negroes attending medical school is decreasing. There are more scholarships available to Negro medical students than there are students to use them. This Committee found no evidence that any medical school in the city does not admit and graduate Negro students on the same basis as white students. In fact, schools seeking a representative student body tend to give a slight preference to Negro applicants for admission.

9. The Committee believes that the present limited Negro enrollment in medical schools is not traceable to discriminatory admissions policies but is rather a persisting reflection of the larger pattern of discrimination against and segregation of the Negro which has discouraged young men and women from attempting to fulfill educational prerequisites for a medical career.

10. Racial integration in the career of nursing is aptly symbolized by the disbanding in 1951 of the National Negro Nursing Association and the closing of the segregated Lincoln Nursing School. Negro nurses are now assigned to positions of all kinds including supervisory, teaching, and administrative posts. It is our conclusion that nursing is as free from discrimination on the ground of race or color as any career opportunity that exists in the city.

11. The number of Negro girls enrolling in nursing school is not keeping pace with the demand for nurses nor with the increasing number of Negro girls who graduate from high school. Our survey indicates that Negro girls studying nursing are concentrated in Bronx Community College and Harlem Hospital. We know of no evidence of discrimination in the admissions policy of any nurse training facility and conclude that the scattering of Negro students in most nursing schools is traceable to factors such as quality of secondary education and counseling received.

12. Color is as great a determinant of life expectancy in New York City as sex. The following figures illustrate this:

Life Expectancy for:

White males	67.3 years
Nonwhite males	60.8 years
White females	73.1 years
Nonwhite females	67.6 years

Color of skin also correlates with the type of hospital facilities used. In a leading hospital in the city, Negroes constitute 80 percent of the patients in wards, 12 percent of the patients in semiprivate rooms, and 3 percent of the patients in private rooms. Participation in hospital insurance does not significantly alter the ethnic factor in the use of hospital facilities.

13. Nondiscrimination in the admission and assignment of patients is required by State law and taken for granted by hospital trustees and administrators. Because nondiscrimination is taken for granted rather than consciously enforced, floor supervisors and admitting clerks are able to segregate patients at some hospitals. When it is made clear to all personnel that a policy of integration is to be enforced, a great forward step will have been taken.

Recommendations

1. That a specific allocation of funds made available by the National Defense Education Act be itemized for the employment of additional secondary school guidance personnel to work with students in the 8th through the 12th grades with a view to encouraging qualified Negroes to enter the medical and nursing profession.

2. That in the allocation of Hill-Burton Act[11] funds for the construction of hospital additions or allocation of other Federal funds for research, patient care, etc., the Federal Government requires of hospitals, as it requires of defense contractors, reports on the number of Negroes employed at various levels including hospital staff and technical employees--it being clearly understood that the presence of Negro physicians on a hospital staff is a fact to be considered in the allocation of such funds. The allocation of Federal funds should also encourage the affirmative efforts of groups such as HIP to achieve integrated medical practice.

3. That to secure compliance with its policy of nondiscrimination in hospitals in employment and patient allocation, the State of New York require hospitals to post the State policy in appropriate places and to evaluate--through interviews with floor supervisors, hospital bed censuses and other means--the effectiveness of the hospital's efforts to comply with State law.

4. That laws be enacted to require medical and dental schools, hospitals, nursing schools, and other similar institutions to preserve for a period of three years any records, documents, and dates dealing with or pertaining to the admission, rejection, expulsion, or suspension of students, applicants for employment, staff appointments, or affiliations and to make such records, documents and data available at all times for the inspection of the Federal, State or City agencies or officials with responsibility for the enforcement of fair employment and educational opportunity laws. Such agencies or officials might include the United States Commission on Civil Rights, the New York State Commission for Human Relations, the New York City Commission on Human Relations, the United States Surgeon General, and others.

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11. The Hill-Burton Act is Federal legislation under which the Federal Government makes grants-in-aid to the individual states for the construction and remodeling of health and hospital facilities.
60 Stat. 1041 as amended, 42 U.S.C. 291-291y (1958).