

Chapter 2

Historical Perspectives of Healthcare Disparities: Is the Past Prologue?

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*It must be Canaan, your first-born, whom they enslave ...
Canaan's children shall be born ugly and black! ... Your
grandchildren's hair shall be twisted into kinks ... [their lips]
shall swell [1].*

Abstract What is the historical background of disparities in healthcare delivery and how did these disparities evolve? The history goes back to slavery, where what Byrd and Clayton have termed the *slave health deficit* originated and was nourished. In this chapter, the concept that slavery gave rise to a racist system of healthcare delivery is explored, and the observation that this system is still operative is documented by several pointed examples. The historical spectrum includes examples from ancient times to the present, from the inception of slavery through emancipation, Reconstruction, the Civil Rights era, and other periods and demonstrates heavy medical, legal, sociological, and religious involvement in shaping the current picture of healthcare disparities.

Keywords Slavery • Healthcare disparities • Supreme Court • Race • Racist • Superior • Inferior • Skin colour • Great Chain of Being • The Bible • Phrenology • Complexion • Mythology • Discrimination • Ku Klux Klan • Prince Henry the Navigator • Galen • Plato • Linnaeus • Abraham Lincoln • Samuel George Morton • *Crania Americana* • Unitarian Hypothesis • Samuel Stanhope Smith • Dred Scott decision • Tuskegee Syphilis Study

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Roots

As was expertly shown in their monumental book, *An American Health Dilemma* [2], Byrd and Clayton have drawn a picture of racist ideology and thinking regarding people of color that has led to a historical profiling of blacks and others as inferior, undesirable, inadequate, and unfit to be placed in the same species as whites. This negative profiling began early on in recorded history, and evidence for this type of attitude can be found in some of the very early writings by noted scholars, scientists, educators, professors, and physicians [3]. Thus, the psychological and attitudinal roots for perceived differences between peoples became established in the minds of the intelligentsia and the power elite, and it was just a short jump to concluding that darker-skinned persons should be subjugated and should receive a different standard of care and handling. Although it is difficult to pinpoint exactly where and when this differential thinking began, there are several instances in recorded ancient history of its existence, such as in Greece during the eras of Plato, Aristotle, Herodotus, and Galen and in Rome during the reign of the Caesars [4].

The practice of discrimination according to skin color may have begun in ancient Greek mythology, which related that differences throughout the world in skin color were created when Helios, the sun god, allowed his son Phaeton to drive the sun chariot. An erratic driver, Phaeton flew too close to certain parts of the earth, causing the residents to become burnished, and too far away from other areas, causing people there to have blanched skin and the environment to be cold.

As to the roots of slavery, a distinction must be made between the ancient form, which resulted principally from warfare with many of the losers being forced into bondage, and modern slavery, which was based largely on subjugating what were deemed to be inferior beings to involuntary servitude. The former was seen in almost every country [5] and white, black, and brown slaves were to be found during the Middle Ages in Christian Europe and in Africa. Christians and Moslems made a crucial modification of this pattern before European trade opened, by capturing and enslaving each other on religious grounds. In the fifteenth century, in the year 1444, to be exact, Prince Henry, the Navigator of Portugal, made another fateful deviation in the annals of slavery when he visited the west coast of Africa seeking the storied great wealth that allegedly lay within its borders. He and his men captured many black natives and sailed back to Portugal with their human booty [6]. Thus, the European slave trade was opened and was to continue for centuries.

During the time that the practice of slavery was flourishing, many scientific opinions were advanced about the physical characteristics of the enslaved blacks. Most of the arguments were about whether blacks were of a separate species from whites. Theories abounded from those who believed in a unitary origin of humans and those who believed in multiple origins or pluralism [7]. The former group included scientists such as Buffon, Cuvier, Darwin, Rush, and Smith; the latter group consisted of others with equally impressive credentials such as Agassiz, White, Caldwell, Meigs, Warren, Morton, Nott, and Gliddon. It should be clear that all of these scientists believed that blacks were inferior to whites, no matter what they thought about origins. One of the earliest scientists of the Middle Ages to

espouse the separate-origin theory was Paracelsus (1493–1541), a Swiss who did not believe that non-whites were descended from Adam and Eve as whites were. Two foci of the argument about whether all humans were of one creation and therefore were of a single species were the statements by the English philosopher John Locke and the pronouncements of Thomas Jefferson. Jefferson, who essentially wrote the Constitution of the United States, held that all men are created equal and by inference are entitled to equal rights and freedoms in a democratic society (although he himself was a slaveholder of note). Locke stated that there was nothing “more evident, than that creatures of the same species and rank, ... born to all the same advantages of nature, and the use of the same faculties, should also be equal one amongst another without subordination or subjection.” The Swedish anthropologist Linnaeus (Carl von Linne’, 1707–1778) produced the monumental work *Systemae Naturae* in 1735 [8], which established the binomial nomenclature that allowed a specimen to be identified by genus and species, and although it included all races of man under one species, it also extolled the alleged physical and other characteristics of Caucasians while denigrating those of non-whites, especially blacks. Nonetheless, it derailed the Great Chain of Being theory [9] which dictated that there was a hierarchical progression of animals from the lowest, apelike forms upward to the Caucasian or Aryan form which occupied the pinnacle position atop the animal world. It suggested that the black race was closest to the apes. This theory had held sway from the time of Plato in the fifth century BC for 2000 years and was the basis of racist dogma relating to physical differences between the races. It was bolstered in the eighteenth century when S.T. von Sommering, a German professor of medicine, performed dissections on blacks and allegedly showed that the anatomy of blacks was closer to that of the apes than was the white man [10].

This concentration on physical differences between the races was reprehensible and was debated in the major medical universities of the eighteenth and nineteenth centuries such as Harvard, Pennsylvania, and South Carolina. Lecturers on the subject of anthropology, which was a relatively new science created by Linnaeus, often drew thousands of attendees. Ethnology was born, and pseudosciences arose, such as phrenology, which purported to document the inferiority of all races to Caucasians based on skull measurements. The most prominent men of medicine and science provided documentation of their ideas that there were substantive differences in physiognomy between whites and the other races, which led them to declare that whites were naturally the dominant race. One example was Baron Georges Cuvier of France [11], the world’s foremost zoologist, who put on display in Europe the so-called Hottentot Venus, a woman from Africa whose most outstanding physical feature was a large derriere due to steatopygia or storage of fat in the buttocks area. At autopsy, other differential features were found, and Cuvier made this a *cause celebre* to exemplify his points about racial differences. Another proponent of this point of view was Dr. Louis Agassiz of Harvard, who held to the single-origin theory on religious grounds based on the Book of Genesis but felt that environmental exposure was the reason for the vast differences between black and white (he later changed over to the multiple-origin side after his first close encounter with blacks in Boston, being struck by the tremendous physical differences between blacks and whites). Count G.L.L. Buffon of France (1707–1788)

apparently subscribed to the same view based upon his concept of specific infertility: the production of fertile offspring by the crossing of different organisms was evidence of a common origin, although Buffon had no doubt about the superiority of whites over other races.

It should be clarified that although Linnaeus, Cuvier, Agassiz, Buffon, and many other anthropologists and scientists of the period from the seventeenth century through the nineteenth century were tenuous advocates of the single-origin theory, they were also strong opponents of the idea that there was parity between the races, and they used all of their research efforts to “document” a hierarchy of the races of man based on physical differences. Even Thomas Jefferson’s close friend Dr. Benjamin Rush, an anti-slavery, liberal activist of the time who wrote, “The history of the creation of man and of the relation of our species by birth, which is recorded in the Old Testament, is the ... strongest argument that can be used in favor of the original and natural equality of all mankind,” felt that blacks were defective as evidenced by their black skin, which he pronounced was caused by “the LEPROSY.” He used the celebrated case of ex-slave Henry Moss of Philadelphia as an example of a black man who was spontaneously turning white (the dermatological condition vitiligo which Moss almost certainly manifested had not yet been described), and he prescribed a number of remedies such as the topical application of muriatic acid and unripened peach juice to be used on Negroes to “cure” their blackness and reveal the whiteness that lay under their skin. A similar view was held by Dr. Samuel Stanhope Smith, who was Professor of Moral Philosophy at the College of New Jersey (Princeton) and later president of that institution. Dr. Smith attempted to reconcile the views of those who favored the single-origin theory based on religious grounds (Genesis) and those who opposed this view based on scientific observation. He attempted to “establish the unity of the human species” in his groundbreaking book, *Essay on the Causes of the Variety of Complexion and Figure in the Human Species*, which he published in Philadelphia in 1797. Smith contended that the black color of the Negro was due to the effect of climate and noted that there was a gradation in complexion in proportion to latitude. He further concluded that blacks were covered by a “universal freckle” caused by the sun. His philosophical opinions about the origin of skin color thus mirrored Greek mythology cited above.

Professor Smith’s unitarian hypothesis set off a firestorm of controversy and debate among the scientific *cognoscenti*. The most important negative reaction came from Dr. Samuel George Morton of Philadelphia, a professor of anatomy and a physician, who put forth an alternate hypothesis based on multiple origins, and in 1839 he published the results of his research in his epochal book, *Crania Americana*. In his book, he provided details of his studies of the skull specimens of the races of man with the intent of demonstrating that there were very important differences to be observed in skull size and inferences to be drawn about corresponding brain size and intelligence. Thus, the pseudoscience of phrenology, created by Viennese physician Franz Joseph Gall (1758–1828) [12], was perpetuated in the USA, with measurements of the human skull with calipers replacing esthetic description. Morton measured the internal capacity of the cranium and determined that the largest skulls were found in Caucasians and the smallest in Ethiopians. In 1840, Morton

concluded “that the brain in the five races of men,” Caucasian, Mongolian, Malay, American, and Negro, was “successively smaller in each,” with corresponding differences in intellect. He also alluded to the superiority of the Caucasian brain. His findings attracted the attention and belief of prominent Americans such as Horace Mann and Dr. John Collins Warren of Harvard Medical School. Morton carried his arguments to the pinnacles of scientific scrutiny, and on the cold night of February 8, 1848 when the distinguished fellows of the Academy of Natural Sciences of Philadelphia met to hear him lecture about phrenology, he presented an 18-year-old Hottentot boy, provided as a courtesy by the American Vice Consul in Egypt, George Robins Gliddon, who was also an amateur anthropologist and fervent phrenologist and collector of skulls. Morton, commenting on the South African boy’s head, described it as completely foreign to the European concept of the ideal physical features for the human species. The “ideal physical features” had been rapturously commented upon in 1799 by the English surgeon Charles White (1728–1813) in his *Account of the Regular Gradation in Man* when he intoned, where else shall we find “that nobly arched head, containing such a quantity of brain ...? Where that variety of features, and fullness of expression; those long, flowing, graceful ringlets; that majestic beard, those rosy cheeks and coral lips? Where that ... noble gait? In what other quarter of the globe shall we find the blush that overspreads the soft features of the beautiful women of Europe, that emblem of modesty, of delicate feelings ...? Where, except on the bosom of the European woman, two such plump and snowy white hemispheres, tipt with vermillion?” White’s conclusion was that Caucasians were the initial link in the “immense chain of beings, endowed with various degrees of intelligence ... suited to their station in the general system,” extending from “man down to the smallest reptile ...” To him, this was evidence of species differences among humans [12].

Shackles and Chains

Advocates of slavery used Morton’s scientific information to justify keeping Negroes in bondage, since it had been scientifically proven that blacks were inferior to whites and quite probably were of a separate species.

How could the deliberations of the most brilliant minds in America be refuted? All that remained was for a legal opinion to be rendered on the rights of the Negro regarding Thomas Jefferson’s principle that all men are created equal and thus were privileged to enjoy the same right to freedom that whites did. An unfortunate decision concerning the question of freedom for a black man was rendered in 1857, which was one of the heaviest blows suffered by anti-slavery and pro-equality forces that would echo through the annals of history for decades up to the present time. This was the infamous case of Dred Scott, a Missouri slave who sued for his freedom after he had spent 4 years in a free state where he had been taken by his master. The case was argued before the US Supreme Court in 1857 which ruled against Dred Scott, who was remanded to slavery. In reading the opinion, Chief

Justice Roger Taney declared that a Negro was worth only three-fifths of a white man and therefore was an inferior being of a separate species who could not be a citizen and who had “no rights that a white man was bound to respect.” This ruling gave legal status to prejudice, stereotyping, and discrimination, and it has had ramifications in all fields, including health care. Effectively, when the Dred Scott decision was handed down, it gave official scientific and legal approval by the federal government for slavery and poor healthcare delivery to blacks.

Another federally related incident, which bolstered the cause of slavery, was associated with the US Census of 1840. Dr. Edward Jarvis, a physician in Boston, made the alarming discovery that the sixth Census had apparently been defrauded to indicate an increase in insanity among free Negroes in the North as compared to enslaved Negroes in the South. The incidence of insanity among free Negroes in the North was 1 in 162.4, whereas it was only 1 in 1,558 among slaves in the South. There seemed to be a correlation between lunacy and latitude among blacks, with an increased frequency or gradient of insanity in the territory from Mississippi to Maine, where every fourteenth Negro was noted to be either a lunatic or an idiot. The pro-slavery forces claimed that this was evidence of the protective effect of slavery over the mental status of blacks, who apparently could not compete in a free society without going completely mad. Determining by detailed analysis that the figures on allegedly insane blacks in many towns in the North exceeded the total numbers of blacks living there, Dr. Jarvis exposed the statistics as fraudulent and published his findings in *The American Journal of the Medical Sciences* in 1844 [13]. Historians suspect that the fraud was perpetrated by John C. Calhoun of South Carolina who, as Secretary of State, was in charge of the Census. His co-conspirators were Gliddon and Morton, who provided scientific consultation to him. This fraud perpetrated by a federal official on a United States Government document was embarrassing, and Calhoun’s conduct was attacked by John Quincy Adams as “so total a disregard of all moral principle” [14]. Dr. Jarvis continued his efforts to have the Census of 1840 corrected or expunged, but he was rebuffed.

This fraud was not an isolated instance of an attack on black mental status. It was part of a pattern that had been seen before and would be seen again. Some of the more recent attacks were by Dr. Arthur Jensen of Stanford and the eugenics movement during the 1960s, by Dr. William Shockley of the University of California at Berkeley (the Nobel Laureate inventor of the transistor who proposed a government plan to sterilize individuals with low IQ scores), and by Dr. Richard Herrnstein and Dr. Charles Murray of Harvard in their 1980s book, “The Bell Curve” [15], which impugned black intelligence and suggested that blacks were intellectually inferior to whites, according to their experiments.

Reconstruction or Deconstruction?

After the Emancipation Proclamation was signed (New Year’s Day, 1863) by a less than egalitarian President Abraham Lincoln (“I will say ... there is a physical difference between the white and black races which I believe will forever forbid the

two races from living together on terms of social and political equality,” Lincoln had declared in his debate with Judge Douglas) [16], the nation entered what was called the Reconstruction era. The ostensible purpose was to bind up the wounds of war, which ended in 1865, and also to provide some type of health-related benefits for poor Negroes who were now on their own, away from the plantations and slave masters. The federal government created the Freedman’s Bureau which authorized certain public land grants dedicated to Negro welfare. The first of these was the establishment of Freedman’s Hospital in Washington, DC followed in 1868 by the building of the first college of medicine for the training of black doctors, called Howard University College of Medicine, near the site of the hospital. This was followed in 1876 by the opening of Meharry Medical School in Nashville, Tennessee. There seemed to be genuine progress towards increasing the standard of healthcare delivery to blacks, but that was not to last. Jealous Southern whites, rebounding from their losses and reversals of fortune during the Civil War, became determined to reclaim their land, their political status, and their control over healthcare matters. In effect, they became dedicated to deconstructing Reconstruction, by kicking out the so-called carpet-baggers whom they viewed as Yankees who ventured into the South to exploit the defeated Confederates and were using the freed slaves as their foils. The Reconstruction Era, which lasted from 1865 to 1877, was established by the Reconstruction Act of 1867 by the Congress in an effort to shore up the miserable post-war conditions in the South. Promises were made to the freed slaves that they would receive reparations from seized confederate property (40 acres and a mule were supposed to be given) [17] in the form of land grants to male heads of households; although the proposal was pushed by powerful Pennsylvania congressman Thaddeus Stevens, this did not materialize to any great extent, and any land that had been confiscated from whites and distributed to blacks was repossessed by the former by order of the Freedman’s Bureau. This was one of the compromises agreed to between the government and the rebel Confederate states to entice the Southerners to rejoin the Union. An effort was made to improve health care for the liberated blacks, who were experiencing their worst health conditions in the immediate post-war period. This dire health situation was partially ameliorated by the Freedman’s Bureau programs cited above, but most of them were not to last, and the Freedman’s Bureau was totally eliminated in 1872. This left freedmen truly on their own and that included responsibility for their own medical care. Fortunately, the move to educate blacks in the medical sciences was growing, and by the turn of the century, 9 of the 11 medical schools dedicated to producing black doctors opened since 1868 were thriving [18] and had produced over 1,000 black doctors. However, the government decided to investigate the quality of all medical colleges in this country and in Canada, and Dr. Abraham Flexner was commissioned to do the job. In 1910, he published his book, *Medical Education in the United States and Canada* [19], in which he recommended that all but two of the nation’s black medical schools be closed – and they were; the only ones allowed to continue were Howard and Meharry, which he suggested should concentrate not on training surgeons or other specialists but should devote their efforts to producing “Negro sanitarians” because Negroes were a source of infection and contagion and as such were a threat to the health of whites. The deficit of schools dedicated to training black doctors

remained until recent years when Morehouse Medical College in Atlanta, Georgia and Drew University in Los Angeles, California, were added. The deficit still remains and still impacts the racial and ethnic minority workforce in the health professions.

Fifty Centuries of Blacks in Medicine

The history of blacks involved in medicine began with Imhotep, an Egyptian from sub-Saharan Africa who lived in Egypt in approximately 3000 BC during the reign of King Zoser the Great in the Third Dynasty. Imhotep was renowned as a sage, philosopher, scribe, poet, chief lector priest, magician, and architect who designed and constructed the Step Pyramid at Sakkara, the world's first large, human-made stone structure. He was most famed as a physician and was the first person to be known throughout the world as a doctor. Imhotep was probably responsible for the production of the seminal Ebers papyrus, which detailed the treatment of more than 700 diseases. There is evidence that he knew of the circulation of the blood and the beating of the heart thousands of years before William Harvey rediscovered these phenomena and wrote about them in his 1628 treatise, *Exercitatio Anatomica De Motu Cordis et Sanguinis in Animalibus* (Anatomical Treatise on the Motion of the Heart and Blood in Animals), published approximately 4,500 years after Imhotep's initial discoveries. Imhotep was deified about 2850 BC, and thus this great African physician whose skills were acknowledged by the noted Greek historian Herodotus came to be recognized as the god of medicine 50 centuries ago – almost 2,500 years before Aesculapius laid claim to the same title in Greece.

In the eighteenth century, a number of slaves contributed to medical science despite their bondage. Onesimus, a slave of Cotton Mather in Boston, is credited with initiating the practice of smallpox inoculation along with Dr. Zabdiel Boylston. Onesimus' work helped to stem the spread of smallpox in the American colonies in 1782, and it no doubt gave Jenner the idea for widespread vaccination that led to his fame. Interestingly, Onesimus and Boylston were vilified for their work because the whites of Boston did not wish to be subjected to medical treatment that emanated from a black person.

In Philadelphia, James Derham was a slave who bought his freedom with the proceeds from a successful medical practice. Papan, a Virginia slave, learned medicine from his masters and became so skilled at treating skin and venereal diseases that the Virginia legislature set him free. Cesar, enslaved in South Carolina, was also rewarded with freedom because of his medical expertise. Primus, another "slave-doctor," was a pioneer in the treatment of snakebite and rabies; when his master died, Primus took over his surgical practice.

There is abundant evidence that, given a chance, blacks could be educated in medicine, could establish and conduct successful medical practices, and could learn to take care of their own healthcare needs. The earliest black doctor in America was Lucas Santomee, who received his medical education in Holland and practiced in

New York during the Colonial period. The first African American person to graduate from a medical school was Dr. James McCune Smith, who graduated from Glasgow, Scotland in 1837. The first black graduate of an American medical school was Dr. David John Peck in 1847. Martin Robison Delaney was the first black to matriculate at Harvard Medical School; he did not graduate; he was blocked by white students from attending classes, and he was eventually expelled after 2 years by the famous Dean Oliver Wendell Holmes along with two other black classmates. Delaney subsequently obtained his medical degree through preceptorship training and went on to serve with distinction as an Army major during the Civil War.

Other notable early black physicians were Dr. John V. DeGrasse, a graduate of Bowdoin College who studied medicine in Paris and was elected to membership in the Massachusetts Medical Society; Dr. Peter W. Ray, born about 1820 and a Bowdoin graduate who practiced in New York City and became a member of the New York State Medical Society; Dr. Edward C. Howard, born in 1846, who graduated from Harvard Medical School and later cofounded Mercy-Douglas Hospital in Philadelphia; Dr. Major R. Abbott, a graduate of Toronto University Medical School; and Dr. A.T. Augusta, an Army doctor who was the first superintendent of Freedman's Hospital [20]. Some other outstanding black doctors in medical history were Dr. Daniel Hale Williams, who performed the first operation (a pericardiotomy) on the living human heart in 1893; Dr. Charles Richard Drew, who was head of the British blood plasma project for the US Army in 1941 and conceived the idea of the blood bank during World War II (this project ran into difficulty caused by those who were upset by the possibility that blood from blacks might be given to whites); and Dr. John Beauregard Johnson, chairman of medicine at Howard University School of Medicine, who first called attention to the serious problem of hypertension in blacks.

Governmental Involvement in Health Care for Blacks

Many times, the federal government has been the instigator and the supporter of biased healthcare. The government aided and abetted racial discrimination in hospitals by supporting (through the provision of Hill-Burton funds in 1946) the concept of "separate but equal" in which it allowed for separate hospitals for blacks and whites with the proviso that the facilities be equivalent. (The "separate but equal" provision had been established by the 1896 Supreme Court decision in the *Plessy vs. Ferguson* decision, in which the Court held that segregation of facilities such as railroad cars and educational facilities was legal as long as the facilities for blacks were equal to those for whites [21]. This ruling was overturned by the *Brown vs. the Board of Education* decision of the Supreme Court [22] in 1954 when segregation in public education was ruled illegal.) This duplication of medical services was difficult to maintain. I had the opportunity to speak with Dr. W. Montague Cobb, the late brilliant scholar/activist/physician/civil rights leader on April 28, 1988 regarding this quandary. He simply stated, "If they can't maintain one hospital

system, how in the world can they hope to operate two?" [23]. When it became obvious that this "Jim Crow" hospital arrangement was a farce, black patients were eventually allowed admission to white hospitals, but only to specially isolated black wards, a situation that Dr. Cobb labeled "deluxe Jim Crow." Black doctors were barred from practicing on their own patients within such institutions. The National Medical Association, an organization of mostly black doctors that had been formed in 1895 to advocate for the right of Negroes to receive a higher level of healthcare delivery and for black doctors to practice freely, held a number of Imhotep Conferences from 1957 to 1963 led by Dr. Cobb at the White House in an attempt to gain equal treatment for blacks, because despite the 1954 Supreme Court decision on *Brown vs. the Board of Education*, segregation in hospitals persisted. The eighth conference in 1963 got the ear of President Lyndon Johnson, who was at that time debating what should be in the Civil Rights Act that he was preparing for 1964. At about the same time, an important test case went to trial; it was to be the "granddaddy" of all hospital desegregation cases. Entitled *Simkins vs. Moses H. Cone Memorial Hospital* and originating in Greensboro, North Carolina, this case led to the declaration by the Fourth US Circuit Court of Appeals that the "separate but equal" portions of Hill-Burton were unconstitutional. Thus ended a 17-year period in which federal funds were used to reinforce hospital segregation. To President Johnson's credit, Title VI of the new Civil Rights Act that was passed in 1964 prohibited racial discrimination in public accommodations, which included hospitals, and it made "separate but equal" illegal. In 1965, Dr. Cobb and his colleague Dr. Hubert Eaton won a discrimination case against Walker Hospital in Wilmington, North Carolina which was the first test case of the new law; it destroyed any vestiges of the "separate but equal" provision and opened up Southern hospitals to black doctors. However, this did not guarantee that the healthcare delivery playing field would be leveled; discrimination did not disappear because it was outlawed by legislation, and in any event, enforcement was almost non-existent and penalties for non-compliance were absent. Indeed, the 1960s may be considered the time period when blatant segregation metamorphosed into subtle discrimination within the healthcare system; racism continued to prevail despite all of the putative legal gains and civil rights advances. Essentially, medical care for blacks was contained in large part within the borders of several urban ghettos and was dispensed through several large municipal medical centers, such as Dr. Martin Luther King, Jr. Hospital in Watts, California, Grady Hospital in Atlanta, Georgia, D.C. General Hospital in Washington, DC, Cook County in Chicago, Charity Hospital in New Orleans, Louisiana, Boston Medical Center in Roxbury, Mass., and Kings County Hospital in Brooklyn, New York. When these institutions became overcrowded, the municipal governments built others like them as well as outpatient clinics, rather than opening the doors and beds of existing hospitals outside the restricted zone. Several high-quality hospitals spurn poor minority patients by simply declining to accept the Medicaid insurance which would pay for the patients' care. Their excuse has been the burdensome paperwork and bureaucratic process which Medicaid requires. In addition, a large percentage of minority patients have no health insurance coverage, and therefore they could not be treated

at private and some public hospitals and in private doctors' offices for financial reasons. This essentially protects such hospitals and most white private doctors' offices from incursions by large numbers of blacks and Latinos, and it has maintained de facto segregation in healthcare delivery in a format of institutional racism, in which the dynamics are driven more by financial incentives rather than medical needs [24]. This renders our system what might be called "wealth care" rather than health care.

The end of the nineteenth century and the beginning of the twentieth century were indeed the hardest of times for blacks. All of the political gains made during Reconstruction were lost, including a total wipeout of all black legislators from Congress, and a loss of voting privileges. There was virtually no organized medical care system for blacks, who had to treat themselves by using root doctors, herbalists, midwives to deliver babies, and voodoo. This neglect continued from the end of Reconstruction into the 1920s and beyond. Some of the responsibility for improving black health was assumed by some charity organizations; the two most active and most effective ones were the Julius Rosenwald Fund, started by the head of Sears Roebuck, and the Duke Foundation. Their public health programs saved countless lives, but more was needed. Having no support system from federal or state sources and having lost all of their political and economic power, blacks were forced to retreat into a situation which was very similar to the serfdom and feudalism that had been found in Europe in agrarian societies. The American version was called sharecropping, which made blacks totally dependent on and welded to white landowners, a situation which was not very different from slavery. To keep the black sharecroppers docile and submissive, the white South invented fearful, repressive, intimidating, and murderous tactics to subvert the Negro and undermine Reconstruction, and the main conduit of these tactics, the Ku Klux Klan, was born in April 1867, in Room 10 of the Maxwell House in Nashville, Tennessee [25]. The notorious Black Codes, which restricted or banned movement and gatherings of Negroes and involvement in political activities, were rigidly enforced in Mississippi and several other Southern states. In essence, the South had declared war on the vulnerable black population and was operating in a decidedly genocidal fashion against its former slaves. Soon blacks were being lynched all over the South on almost a daily basis, and their re-subjugation was complete.

It should be clear that white physicians had been indoctrinated by the teachings of scholars such as Louis Agassiz, Josiah Clark Nott, Charles Caldwell, Baron Cuvier, G.L.L. Buffon, Samuel George Morton, John Augustine Smith, and many others, who essentially declared that blacks were inferior beings. They therefore developed certain stereotypes and attitudes about blacks and the medical and psychological conditions that they suffered. These attitudes became mixed into the manner in which white doctors approached black patients. One notorious exponent of the view that blacks were inherently inferior and possessed defects of the nervous and cardiovascular systems making them susceptible to diseases such as syphilis, yaws, and degeneration of the circulatory system was Dr. Samuel A. Cartwright of New Orleans. In 1851, he wrote in the *New Orleans Medical and Surgical Journal* that the difference in health status between blacks and whites was

due to the perception that “the Negro’s brain and nerves, the chyle and all the humors are tinged with a shade of pervading darkness” [26]. Similarly demeaning and pejorative statements were made by Dr. M.M. Weiss when he wrote in the *American Heart Journal* in 1939 that blacks experienced less chest pain or angina pectoris than whites because “more than moronic intelligence” is necessary to perceive the sensation of pain [27]. Blacks also felt distrustful of white doctors, believing that they might become unwilling and unwitting subjects of human experimentation; these suspicions were confirmed in 1928 by E. Franklin Frazier [28]. They were later upheld by the notorious Tuskegee Syphilis Study, carried out by the US Public Health Service from 1932 to 1972. In this study, 400 black male residents of Macon County, Georgia, who were found to have syphilis were given only placebo treatment by medical professionals and were followed to their deaths. The purpose was to allow the Public Health Service doctors to study the natural history of the disease and to observe its pathological effects at autopsy [29].

Racial and Ethnic Differences in Disease Expression

The racist statements cited above by Cartwright and Weiss indicate the interest that was generated in whether blacks and whites experience illness differently and whether everyone should be treated the same (the “one size fits all” controversy). Are blacks more susceptible to certain diseases than whites? Do African Americans exhibit resistance to particular illnesses that are seen in Caucasians? If there are differences, are they due to genetic causes, or is environment the reason (the “nature or nurture” controversy)? Do differences in manifesting illness and responding to treatment imply that one race is more or less fit for survival than another (the “superiority vs. inferiority” debate)?

These issues have been argued down through the centuries, and they still are. Many books have been written and positions have been taken to put forward one point of view or the other. Suffice it to say that there is no uniform agreement on any of these key issues, but there is a recognition today that some differences in disease expression and response to treatment do exist and that it is best to individualize treatment and tailor it to the person as he or she presents with various characteristics such as race and ethnic group.

In 1975, I edited the *Textbook of Black-Related Diseases* [30] in an attempt to address some of these concerns. The book was a large compendium of information available on diseases across the medical spectrum as they are experienced by blacks compared to whites in America. It was intended to fill a void, because only a small literature was available on the principle diseases affecting blacks. This was due in part because vital statistics containing morbidity, mortality, longevity, incidence, and prevalence figures, which have only been collected in recent years, were not collated according to race. Medical decisions were based on anecdotal information, and expert opinion and judgment were the standards for doctors’ treatment. Prior to the establishment of federal health programs and the creation of clinical trials and studies of health phenomena, there were no objective, evidence-based data to use.

This book started a trend involving the collection of health data by race and ethnicity as well as consideration of the patient's racial background in diagnostic and therapeutic applications. It also documented clear differences in vital statistics between blacks and whites and showed the tremendous disparities in health care and outcomes in graphic terms. It led to further exploration and analysis of the background, causes, and extent of the disparities and was a direct stimulus and precursor of the Malone-Heckler Report on the status of healthcare delivery for blacks and other minorities, which was issued by Secretary Margaret Heckler's Department of Health, Education, and Welfare in 1985 [31]. A recent example of the value of the collection of health data by race and ethnicity was a study presented at the American Society of Chest Physicians in October 2006. The study of 10,053 deaths from pulmonary arterial hypertension from 1994 to 1998 which were recorded by the National Center for Health Statistics revealed that black women had the highest risk of dying from the idiopathic form of the disease, a previously unrecognized and extremely important epidemiological fact. According to the lead investigator, Kala Davis, M.D. of the Stanford University School of Medicine, "race, gender, and age have become defining factors in assessing the risk of death in idiopathic pulmonary arterial hypertension. Clinicians must therefore be cognizant of this emerging demographic profile, which contrasts with the classic description of the condition as being a disease of middle-aged Caucasian women [32]."

From 1985 to 2000, there were no major publications on the health status of blacks and other minorities in the USA. In 2000, *An American Health Dilemma* was a breakthrough book, which revisited the problem of black health care in a major way for the first time in 15 years. The Institute of Medicine (IOM) Report was the next step in the progression. Once again, as in 1985, the problems have been described and recommendations for solving them have been made. There seems to be an overwhelming inertia that prevents us as a nation from putting a halt to these discrepancies in healthcare delivery and leveling the playing field. The next milestone that has been established for improvement of health goals is Healthy People 2010, which has two overarching goals: increased longevity and a significant reduction of healthcare disparities. Sadly, history indicates that we will not achieve the latter by that date.

Conclusion

The historical saga of blacks and American medical care is an ongoing story, and what is detailed above is but part of the litany of morbid events. The purpose of this overview is to familiarize the reader with the events, which are directly responsible for the healthcare disparities that we are witnessing today, and to realize how much we as medical practitioners are the cause of those disparities. The principle focus has been upon how racist attitudes developed over the centuries and how they have impacted the delivery of health care to African Americans. As one reads the remainder of this book, one should keep these events and attitudes in mind, because they influence every aspect of black and minority health care and also because the nation

is still very much affected by these influences. Hopefully, this brief review of the past will help us to eliminate current healthcare disparities and to resist similar events from occurring in the future. The survival of an entire race of people depends on our ability to interrupt such a negative impetus.

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