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HISTORY OF MEDICINE: PEER-REVIEWED ARTICLE

Living Histories of Structural Racism and Organized Medicine

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Abstract

This article reassesses and recontextualizes findings of an independent writing group commissioned in 2005 by what was then known as the Institute for Ethics of the American Medical Association (AMA). The authors were members of this group, which uncovered a paradigm case of structural racism that has perpetuated health inequity since the issue of admitting African Americans was first raised at the AMA's national meetings immediately after the Civil War ended, in 1868. Upon publication of the writing group's findings, the AMA publicly apologized for its social, cultural, and political roles in the racist history of organized medicine. Now, in 2021, the authors of this article seek to situate this aspect of the AMA's history as it prepares itself for antiracist leadership in the health care sector.

Historical Record

It is tempting to believe that since the medical profession is dedicated to employing the biomedical sciences to prevent and heal illnesses, the inherently benevolent goals of the profession would serve to insulate it from bigotry and racism. Sadly, the historical record suggests otherwise. Recognizing this, in 2005, the Institute of Ethics of the American Medical Association (AMA)—then led by the second author—commissioned an independent panel, the Writing Group on the History of African Americans and Organized Medicine, to analyze the AMA's history on issues of race.¹ In this article, the authors—both of whom identify as White men who participated in the original study—reassess and recontextualize these research findings,¹ recognizing them as describing a paradigm case of structural or systemic racism—terms not widely used at the time. (Stokely Carmichael and Charles V. Hamilton first coined the term *institutional racism* in their 1967 book, *Black Power*, and this term is largely synonymous with systemic racism.²) In short, the Writing Group's research clearly documented the AMA's role in creating structural racism, defined as “a system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity.”³

After the research group reported back to AMA's Board of Trustees, in July 2008, immediate past President Ronald Davis issued a formal public apology to the National

Medical Association (NMA),¹ the historically Black medical society created in 1895 when most Black physicians were unable to join the AMA.

I humbly come to the physicians of today's National Medical Association to tell you that we are sorry.... on behalf of the American Medical Association, I unequivocally apologize for our past behavior. We pledge to do everything in our power to right the wrongs that were done by our organization to African-American physicians and their families and their patients.⁴

Davis also wrote a moving commentary that accompanied the Writing Group's article describing this history, and both pieces were published by the *Journal of the American Medical Association (JAMA)* in the July 18, 2008, issue. In his commentary, Davis summarized the Writing Group's findings about how "the AMA failed, across the span of a century, to live up to the high standards that define the noble profession of medicine" as follows:

(1) in the early years following the Civil War, the AMA declined to embrace a policy of nondiscrimination and excluded an integrated local medical society through selective enforcement of membership standards; (2) from the 1870s through the late 1960s, the AMA failed to take action against AMA-affiliated state and local medical associations that openly practiced racial exclusion in their memberships—practices that functionally excluded most African American physicians from membership in the AMA; (3) in the early decades of the 20th century, the AMA listed African American physicians as "colored" in its national physician directory and was slow to remove the designation in response to protests from the National Medical Association; and (4) the AMA was silent in debates over the Civil Rights Act of 1964 and put off repeated NMA requests to support efforts to amend the Hill-Burton Act's "separate but equal" provision, which allowed construction of segregated hospital facilities with federal funds.⁵

This brief list omitted several of the panel's other salient findings, such as AMA support for the Flexner Report as part of a broader education reform movement that contributed to the closure of all but 2 historically Black medical schools.^{6,7,8} In addition, as our reports were limited to the mistreatment of Black physicians, we did not describe the AMA's support for other racist policies, such as the Chinese Exclusion Act⁹ or eugenic policies.¹⁰ Nevertheless, reflecting back on the research that we and our colleagues in the Writing Group carried out, we now believe that the deeper point we unearthed was that the AMA played a key role in establishing and encouraging foundationally racist structures for organized medicine, even while sometimes arguing against interpersonal racism. The history of how a powerful social organization can decry racism, even while reinforcing social structures that **predictably create racist outcomes** may be of value today as we consider how best to move forward in addressing persistent racial and ethnic health disparities. To illustrate some key lessons, we review the 4 points listed by Davis to show how each fomented and defended a racist infrastructure that continues to perpetuate the racial divide in American health care and health outcomes to this day.

Exclusion of Black People From Medicine

Immediately upon its founding in 1847, the AMA became the national organizational base for allopathic medical practitioners, medical schools, and health care facilities (eg, asylums, clinics, dispensaries, hospitals).¹¹ During this period of American history, several major egalitarian movements were founded, among them the American Anti-Slavery Society (1833), and the first wave of American feminism emerged, announcing its birth in the Declaration of Sentiments of 1848.¹² In the 2 decades following the establishment of the AMA, the conflict over slavery erupted into US civil war, which ended in the defeat of the Confederacy and the passage of the Thirteenth Amendment ending slavery outside of penal settings in 1865 and the Fourteenth and Fifteenth Amendments in 1866, which gave newly freed Black men equal rights to citizenship.

After a 2-year hiatus in its national meetings during the war, in 1868 the AMA was faced with whether to admit to its national meeting female physicians and Black physicians, all holding medical degrees from allopathic (as opposed to homeopathic) medical colleges. Seeking to resolve the issue, Nathan Smith Davis, who fashioned himself the “Father of the AMA,”¹ proposed that since the AMA “had never taken action on any matter which distinguished practitioners either on account of sex or color, if any local association saw fit to enact a law restricting its members, that was a matter for such societies to determine” and the national society should not intervene.¹² His motion passed.¹² Thus, 2 years later, in 1870, when 4 representatives of the allopathic National Medical Society (NMS) of Washington, DC—Robert Reyburn, a White veteran of the Union army and dean of Howard University Medical College, and 3 Black colleagues—presented credentials to the AMA national conference, they should have qualified for admission. However, a White Washington, DC, medical society challenged their admission to the conference, charging that the NMS had violated canons of collegiality by complaining to the US Congress about the White medical society’s discriminatory refusal to admit Black physicians. The dispute went to an AMA ethics committee, which ruled against admitting delegates from the racially integrated society to the national conference.¹³

To clarify the precedent being set, a motion was proposed stating that “no distinction of race or color shall exclude from the Association [the AMA] persons claiming admission.”¹³ This motion was rejected (tabled, 106 to 60). A second motion—that “consideration of race and color has had nothing whatsoever to do with the decision of the question of the Washington delegates”—passed (adopted, 112 to 34).¹³ The AMA thus rejected members of a racially integrated local society, voted down a statement of nondiscrimination, and then—mindful that this act appeared to be blatantly racist—whitewashed its actions, officially denying that members’ racist votes had anything to do with “race and color.”¹³ In 1872, Reyburn and his Black colleagues from Howard Medical College again sought entrance to the AMA’s national meetings but were again rebuffed. Reyburn then exhorted the AMA to “consider well what they were doing ... [since] every human being should be allowed the right to the very highest development that God has made him capable of.”¹²

Irritated by the distraction caused by Black (and female) physicians seeking to attend the AMA’s national meetings, in 1873 and 1874, Davis initiated rules giving state societies complete control over “which local societies should be officially recognized by the AMA,”¹³ thereby ensuring that debates over racial (and gender) admission would not disturb the good fellowship of the AMA’s national meetings. This structural change had the immediate effect of permitting Southern societies to exclude Black physicians from the AMA—and, despite many subsequent statements against racism, the AMA defended this fundamentally racist policy, treating discrimination as an immutable fact of life, until forced to abandon it by the civil rights laws of the 1960s.¹

Thus Davis, seeking to secure reunion with well-established White medical societies of the South (and, based on his actions, perhaps personally sympathetic to the view that medical societies were in part social clubs to which Black people and women should not be allowed entrance), gave up the civil rights of Black physicians, trashing the integrationist ideals of White Union soldiers like Reyburn and his Black colleagues in the process. Predictably, in the South, AMA policy led to nearly a century of formally **race-segregated medical societies** during a period when membership in an AMA-affiliated medical society conferred de facto admitting privileges at local hospitals and access to business loans and advanced training opportunities, thereby systematically

disadvantaging Black doctors and their patients.¹³ This structure of discriminatory policies led to a century of intentionally 2-tiered medicine throughout the South, separate and unequal, and to the informal but still structural racial segregation of health care that persists today.

Nationalization of Racial Stigma

Professionals have letters affixed to their names—DDS, MD, MPH, PA, PhD, RN. Like the diplomas and certificates that adorn doctors' office walls, these are indicators of educational and professional qualifications and attainments. Yet, in 1906, when the AMA began publishing a directory of all allopathic physicians practicing in the United States, some of the names had "col" affixed to them. These 3 letters were not indicators of educational or professional attainment; they were indicators of a physician's race—*col* meant *colored*, thereby marking Black physicians as other than White. The *col* designation generated social stigma, and the fact that some of the effects of this stigma were outside the direct control of the AMA did not diminish their very real impact. According to the NMA, the *col* designation "worked several hardships" for Black doctors, including "the cancellation of their [physicians'] malpractice insurance and in their being refused credit."⁶ Like the yellow Star of David and the pink triangles that Nazis forced on Jewish and gay people, respectively, the *col* designation functioned as a stigma, a mark of the other. The AMA's decision to designate physicians as *col* was a policy decision that created a social structure that facilitated, if not actively encouraged, racist norms and behaviors. Today, many will also recognize the *col* designation as overtly racist in its own right, since designating someone as "colored" implies a meaningful distinction between people based on skin color. That this racist implication was not noted at the time may be an indicator of how entrenched the notion of biological differences between "races" had become by the 1930s—and foreshadows ongoing problems in medicine of using the social construct of race as though it has significant biological or genetic meaning.¹⁴

Battle of Oaths

The final item of Davis' apology singles out the AMA's failure to support the NMA's attempts to change the funding of racially separate and overtly unequal health care facilities. Yet the AMA's resistance to **civil rights laws** was more insidious than merely failing to support the NMA's policy position against the Hill-Burton Act, which allowed for racially segregated hospitals; it took a form that might be called "the battle of the oaths." As part of its plan to ensure compliance with new civil rights laws, the US Department of Health, Education and Welfare (HEW) forbade "racial discrimination in the selection of physicians as interns, residents, and admitting staff, nor could they legally exclude or segregate patients on the basis of race," and the proposed regulations "required all recipients of federal funds, including physicians, to sign a statement of compliance, formally forswearing racially discriminatory practices."⁶

The AMA House of Delegates opposed this requirement and voted against integrating hospital physicians and house staff and against signing statements of compliance. It directed its staff to "oppose actively and forcefully this and any future attempts by HEW or any other federal agency to impose conditions and pledges upon the medical profession," deeming oaths of compliance with civil rights laws to be "'discriminatory' towards physicians and 'degrading,' because physicians already had a code of ethics that forbade discrimination."⁶ HEW dropped the requirement: physicians were thereby exempted from a key provision of the Civil Rights Act of 1964—an exemption that our writing group noted "persists, and has repercussions, to this day"⁶—and the AMA took

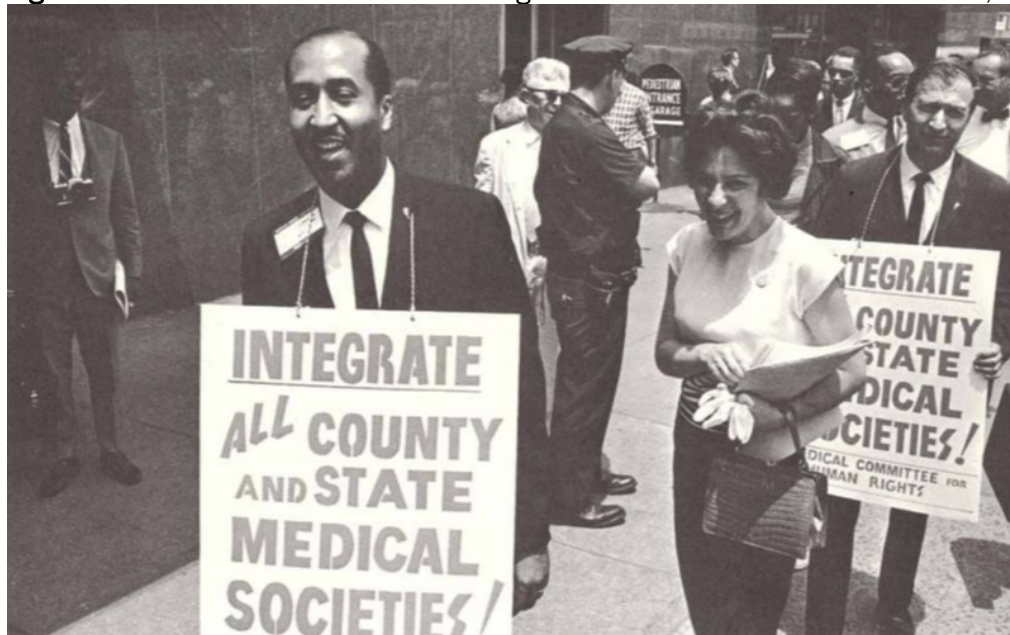
credit for physician offices being able to flout requirements of the Civil Rights Act under the guise of protecting professional autonomy.⁶

Figure 1. Annual Meeting of the American Medication Association, 1966^a



^a Reprinted with permission from the American Medical Association Archives.

Figure 2. Protestors at the Annual Meeting of the American Medical Association, 1966^a



^a Reprinted with permission from the American Medical Association Archives.

Yet the AMA's core argument—that oaths of compliance were not needed and were insulting because its *Code of Medical Ethics* already prevented discrimination—was patently specious. The argument's flaws should have been evident from the AMA's long acceptance of segregated medical societies and its tolerance of clinics, emergency rooms, and hospitals with "Whites only" signs on their walls. The members of the AMA's House of Delegates were virtually all White at the time (see Figure 1), and AMA meetings of this era were routinely picketed for their lack of attention to blatant racial discrimination then widespread in medicine (see Figure 2). Moreover, nothing in the traditional Hippocratic Oath or in the AMA *Code of Medical Ethics* operative at that or at any prior time prohibited discrimination against patients or physicians based on race or ethnicity. In fact, discrimination against patients was specifically permitted by Section Five of the 1957 AMA Principles of Medical Ethics, which stated: "A physician may choose whom he will serve."¹⁵ The HEW's deference to the AMA on this point is a testament to the capacity of professional arrogance and power to reinforce White privilege with the argument that racism among physicians doesn't exist.

Dismantling Structures Perpetuating Racism

The Writing Group limited its formal historical review to the period 1847 to 1968, but the group also acknowledged a number of important events between 1968 and 2008—such as the election of Lonnie Bristow as the AMA's first Black president in 1994 and the AMA's work with the NMA to form the Commission to End Health Care Disparities in 2004—and noted that "this history is still being written."¹ This sentiment is as true today as it was in 2008. Indeed, some important history has been written in the years since the AMA issued the apology. For instance, in 2005, 3 years before the AMA's apology, Black people composed 12.3% of the US population but only 2.2% of US physicians and medical students, and, in 2006, they composed a mere 1.8% of AMA members.⁶ By 2019, Black people composed 4.2% of all physicians and medical students and 4.6% of AMA members.¹⁶ The fact that there are more Black physicians and more Black AMA members today than in 2008 is progress, but Black people remain dramatically underrepresented within the profession. Similarly, the appointment of Aletha Maybank Harris as the AMA's first chief health equity officer in 2019¹⁷ and the election of Patrice Harris to the AMA presidency in 2019—the first Black woman to hold the position¹⁸—were moments to be celebrated, as was the AMA's recent decision to remove the bust of Nathan Smith Davis from its prominent place in the headquarters building and to rename an award named for him,¹⁹ as well as the AMA's first formal declaration, in 2020, that racism in the US is a public health crisis.^{20,21} Yet the fact that these "firsts" took place so recently is more a reminder of how far the organization has to go than a reason to celebrate how far it has come.

The contours of the hard road ahead for the AMA were reinforced in early 2021, when *JAMA* (which, like the *AMA Journal of Ethics*, is editorially independent of the AMA) issued a Tweet claiming "No physician is racist" to promote a podcast in which a deputy editor argued that the phrase "structural racism" is "an unfortunate term" because it makes him and other White physicians feel offended.²² Both the AMA and the AMA's chief health equity officer expressed outrage and promised further investigation and action.²² The Tweet and podcast were rapidly deleted, *JAMA's* editor-in-chief issued an apology, the deputy editor involved resigned, and the editor-in-chief eventually did, too.²³ These events demonstrate just how prescient was Davis' 2008 *JAMA* commentary in describing the most profound challenge that would face the AMA on its path to becoming an antiracist organization (a term not yet coined at the time²⁴). He noted:

Psychological research suggests that whites and African Americans tend to view changes in the racial milieu in different ways. Whites tend to see full equality of opportunity as an idealized goal, and they measure progress by comparing the present and the past, noting how far society has come; but African Americans and other nonwhites are more likely to see racial equality as a necessary condition for justice and to judge current racial inequalities against a future of equal opportunity, which still seems far off.²⁵

Davis didn't quite say it at the time, but we now believe he might have recognized that the challenge facing the AMA, then and now, is the same as that facing all White people—or, more accurately, facing all those whom the journalist and author Ta-Nehisi Coates refers to as “people who have been brought up hopelessly, tragically, deceitfully, to believe that they are white.”²⁶ It is the challenge of confronting our created and enforced separation by skin color. In other words, for White physicians leading the AMA, it is relatively easy to proclaim a desire to become an antiracist organization and even to take some actions to support Black physicians. But becoming antiracist requires first that those with often-unrecognized privilege take full ownership of a shared history in which some were systematically marginalized and disadvantaged—recognizing that the story of Black physicians and the AMA is not Black history, it is the history of American medicine and of America. Only with this **level of ownership** of the history can the organization's leaders then take up the second and even more daunting challenge of seeing with open eyes and feeling with open hearts that there are social and professional structures today that arise directly from this history and that continue to sustain and nurture racism in health care—and that these structures must be torn down and rebuilt, not because they harm Black and other marginalized physicians but because they harm all of us, including those who continue to benefit from them.

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