Editorial: Anniversary—A Time for Reflection

The American Public Health Association, 125 years old this year, has outlived any documented individual human life term. Many voluntary organizations have not survived as long, and still fewer organizations in which the membership, remarkably varied albeit professional, has always been the spearhead of a social movement. Continuous and largely altruistic endeavor in good causes—high thinking but little high living—gives us fair grounds to celebrate our survival. At this time also, we approach the second millennium. Given the propensities of many societies for war and the weapons of mass destruction with which human inventiveness has burdened this century, for that anniversary too survival alone could be grounds for celebration.

Most of us probably feel that anniversaries are the occasions for celebrating more than mere survival. So, in his election campaign, President Clinton took the sunny lesson of bright mornings from President Reagan and stimulated much talk of bridges to a brighter future. Of course, he had learned well the lesson in frankness President Carter had inadvertently left for his successors, which was at all costs to avoid mention of misery and the macabre.

Anniversaries, as we see them, are not the best time for messages of unsullied optimism and the best of all possible worlds. They are as much a time to turn to the past as to the future. We can do more for the future mental health of our organization and our movement if we go beyond congratulating ourselves on mere survival, lauding our many (genuine) achievements, and promising ourselves and everyone else happiness to come. We believe, in short, that this is a good time to remind ourselves of our past, a time to reexamine and reconsider.

The Journal has chosen to mark the moment in this spirit. We do not subscribe to the skepticism of many about history. Henry Ford has had allies in dismissing history as "more or less bunk"; Thomas Carlyle, for instance, saw history as no more than the biographies of great men or, merely, a "distillation of rumour." Some modern historians themselves reject the purposive study of history as a guide to interpreting the present and predicting the future.

Societies, organizations, and individuals must, of self-evident necessity, cast off many inherited constraints. Moorings to the past must be cut in order to cope with a world changing with unprecedented and ever increasing rapidity. It does not follow from such necessity that we have nothing to learn from history.

Every society is steeped in its past, whether knowingly or not. To comprehend how and why institutions and cultures came to be the way they are requires us to comprehend their pasts. Those who close their eyes to the past must navigate blind in the shoals of the present. As for the future, they are liable to have cast off valuable cargo for ballast.

For such reasons, the Public Health Then and Now department of the Journal has always had a secure place under its successive distinguished editors, namely, George Rosen, Barbara Rosenkrantz, Robert Korstad, and Elizabeth Fee, who has lately been joined by Theodore Brown. And for this anniversary, we give over the greater part of the Journal to that department.

Drs Fee and Brown have put together an array of papers that do much to inform us about public health in past years. Readers will find that not all of these encourage complacency. For the sake of the occasion, we have put our regular scientific fare aside, convinced that readers will enjoy and profit from the material our editors have assembled. □

Mervyn Susser,
Editor

Annotation: Racism Resurgent—Building a Bridge to the 19th Century

"Slavery," former Senator Bill Bradley observed not long ago, "was America's original sin, and race remains its unresolved dilemma."[1] He might well have added "and racism is its chronic disease." That chronicity is illustrated by three articles in this issue of the Journal—contributions that are nominally historical but resonate profoundly in the present and have particular relevance to current challenges to medicine and public health.

Gamble points out that the deep mistrust of the institutions of medicine and public health felt by many African Americans does not merely stem from the Tuskegee Syphilis Study, as is frequently assumed, but long preceded that event.[1] Tuskegee, she demonstrates, was only one event in a cumulative experience of several hundred years of pseudoscientific racism and pervasive discrimination in medicine, unethical and often brutal experimentation, and abuse of Black people by both private institutions and government programs in health and social welfare.

Pernick examines the ways in which both the overtly racist American eugenics movement and the concepts of public health were influenced by popular culture in the early 1900s to produce striking commonalities (as well as important differences) in the underlying values and approaches to disease of these two fields.[2]

Rosner and Markowitz document the history of blatant and shameless racism in the placement and treatment of orphans and foster children in New York City by both public and voluntary sectarian agencies—policies and practices still not completely curbed, despite decades of protest and lawsuits.[3] The long-term consequences to the mental health and well-being of minority children, as the authors carefully note, are evident today and provide ample grounds for suspicion of seductive calls for the return of an orphanage system.

Why should these explorations of history's long shadows be of such contemporary concern? Because they underscore the extent to which racism—fluctuating in intensity, shifting in content, but ever present—is still a major public health problem and a challenge to the goals of medicine. It is true, as Pernick points out, that scientists (though not the general public) now understand that race is a social construct, not a legitimate biological category. (As one investigator has cogently observed, "the fact that we know what race we belong to tells us more about our society than about our genetic makeup."[4]) But that social construct has its

Editor's Note. See related articles by Gamble (p 1773), Pernick (p 1767), and Rosner and Markowitz (p 1844) in this issue.

own perils: selective and skewed associations of social and behavioral phenomena with race, and the projection of such stereotyping onto individual patients, can have consequences of even greater import than the insulting and dehumanizing examples cited by Gamble.

Consider, for example, the most recent additions to the extensive literature demonstrating persistent racial and ethnic disparities in the allocation of diagnostic and therapeutic resources to African-American patients. These range from the most basic elements of clinical care (history, physical examination, laboratory and x-ray tests)[5] to the decisions to supply or withhold such high-technology modalities as angiograms, angioplasty, coronary artery bypass grafting,[6–11] renal transplants,[12–14] hip and total knee replacements,[15,16] carotid endarterectomy, and other procedures. With increasing sophistication, many of these studies have been controlled and adjusted for such confounding variables as health insurance status, income, education, severity of disease, comorbidity, behavioral risk factors, and hospital type and resources. In one recent study, Blacks were 32% less likely than Whites with comparable disease to receive bypass graft surgery. The differential held true even among patients with the most severe disease and the greatest predicted benefit of survival—and 5-year survival was significantly lower for Blacks.[17] The one ongoing study that is looking directly at the decision-making process finds that "patient refusal accounts for a very small proportion of the racial differentials,"[18] raising the probability that the differentials are the result, instead, of covert or unconscious racial stereotyping by physicians in their assessment of patients' suitability for such procedures.

If this is so, then one of the roots of the situation may be a profound lack of understanding, on the part of the overwhelmingly White medical and public health professional workforce, of the differential life experience of minorities in the United States. This experience includes not only structural racism—environmental, economic, and educational—but exposure to the repetitive assaults of bias, discrimination, and the unfairness of everyday racism[19,20] and their consequences for health. Yet only a relative handful of schools of medicine and public health provide formal training in cultural sensitivity and human rights.[21,22]

Developing and pursuing agendas for action (for example, broadening medical and public health quality assurance systems to monitor for racial disparities) and for research are all the more important in a time of racial retrenchment. Julian Bond has noted the eerie similarity of current events to the period following Reconstruction, when racial justice and equity were abandoned as national goals.[23] The contemporary assaults on civil rights, affirmative action, the social safety net, public housing (other than prison cells), and health care for the poor all have thinly disguised elements of racism. As we approach the millennium, there are political forces busily attempting to build a bridge to the 19th century. The articles by Gamble, Pernick, and Rosner and Markowitz that appear in this special issue of the Journal have a contemporary message. This is not just history. □

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