MEDICAL HISTORY

A CHRONICLE OF RACISM: THE EFFECTS OF THE WHITE MEDICAL COMMUNITY ON BLACK HEALTH

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At no time in history has the health of black Americans equaled that of white Americans. This distinction is particularly evident in the South, where blacks have been subjected to governmental policies promoting discrimination and segregation. The explanations offered for this difference in health status are numerous. The argument presented in this article is that the health status of blacks in the United States has been greatly affected by the attitudes and perceptions of white physicians. From the days of slavery to 1992, the policies and practices of the white medical community have had an enormous impact on the health of blacks. Black physicians have played a large role in changing the delivery of health-care services to the black population. Their fight was a microcosm of the Civil Rights activities taking place in the world around them. This article describes the history of medical care as it relates to black patients and physicians. The progress that has been made over the past century is analyzed, and the need for continued education and persistence is emphasized. Legalized segregation may have been outlawed in the 1960s, but the nation's vital statistics indicate that equality has yet to be achieved. (*J Natl Med Assoc.* 1992;84:717-725.)

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> In appraising medical services in this state, one must take into account the fact that more than 50% of the population in Mississippi are Negroes and that the demand for medical service among this group may fall below the requirements of the white population.[1]

Demand for medical care is just one of many explanations given for the differences found in the health status of whites and blacks. Vital statistics indicate that blacks in the United States have consistently suffered from poorer health than their white counterparts,[2-4] but the reasons for this divergence have been the topic of extensive debate. Genetic make-up—the idea that blacks are simply biologically more susceptible to disease—is perhaps the most popular interpretation. Other arguments link culture to health, particularly focusing on the notion that blacks practice home remedies and believe in the less scientific methods of voodooism and healing through witch doctors. Modern sociologists explain differences in health status by looking at differences in socioeconomic status. The relationship between the two cannot be denied, but the underlying causes also must be explored. Poverty, rather than any specific medical disorder, is the greatest contributor to mortality for both blacks and whites. The question to answer, however, is why, with all other factors held equal, blacks remain above whites for all indicators of poor health.

An obvious answer to this question is racism. The consequences of prejudice and discrimination are staggering, poor health status being one that is the most apparent and dangerous. The prejudices of one group in particular have had a great impact on the experience black Americans have had with the health-care system. Throughout American history, white physicians have enjoyed a status in society that empowered them to influence ideology and make decisions for entire popula-

tions. Currently, physicians feel as though their autonomy and power are being replaced by cost-containment regulations, yet hospitals, patients, and politicians are still greatly influenced by the medical profession. Although the physician's role as "patient agent" suggests that all decisions are being made in the patient's best interest, the doctor's control over information places him or her in a unique position to subject the patient to his or her authority. The health status of blacks in the United States has been greatly affected by the attitudes and perceptions of white physicians. The treatment of black patients and black doctors by the dominant white medical community cannot be overlooked when trying to explain the differences in white and black health status.

The consequences of racism are an issue in both northern and southern states, but it is in the South that blacks have been victims of legalized discrimination. De facto segregation is rampant in the North, and health statistics indicate that northern blacks have consistently suffered from differential treatment.[4,5] Despite the importance of studying the relationship between white physicians and northern blacks, a detailed analysis of the experiences of blacks with health care in the North and South would prove too broad for an article of this length. Therefore, this article focuses on the effects of the white medical community on the health of southern blacks.

The literature written by and for physicians provides an excellent source of information about their ideas and attitudes. It is through the *Journal of the American Medical Association,* the *Journal of the National Medical Association,* and other examples of contemporary medical literature that one can attempt to enter the minds of late 19th and 20th century physicians, both white and black.

SLAVERY AND RECONSTRUCTION

While millions of black Americans lived in bondage, the American Medical Association (AMA) was born. In the mid-1840s, a small, elite group of leading physicians initiated a series of conventions designed to reorganize and defend their profession against the "unprofessional" homeopaths, Thomsonians, and eclectics. In 1847, the conventions culminated in the formation of the AMA.[6] The creation of a formal organization secured the physicians' role and status in society, but did little to cure disease and promote health. Heroic medical practices remained very popular in the 1840s. For the patient, "modern" health care was often more detrimental to health than the natural course of the disease. Despite this reality, physicians' practices were booming as white Americans demonstrated their belief in science and professionalism.

Slaves were in a very difficult position with regard to health care. Most masters required that slaves must receive immediate attention when taken ill. This policy led many historians to believe that slaves actually benefited from their position; cliometricians argue that slaves were very well-off in terms of nutrition and health care compared with northern industrial workers.[7,8] This theory overlooks the danger of the medical care given to southern blacks. Physicians were quite rare in the South, and their services were usually too expensive to waste on slaves.

Furthermore, those masters who were willing to invest in medical care for their slaves had a difficult time finding doctors who would treat blacks. As a result, most healing was performed by the masters themselves. Overdoses, overbleeding, and overpurging were not uncommon. In those instances when doctors were summoned, slaves were usually victims of sloppy medical care. Unless physicians were liberally compensated, they probably did not maintain the highest standards in their care of slaves; the only guard against malpractice was the physician's conscience.[9]

Moreover, even physicians who believed they were giving adequate care gave differential treatment to blacks based on their perception of black anatomy and biology. The popular notion that blacks required different treatment because of lower sensitivity to pain and unpredictable reactions to medication influenced the medical care given to them.[6] As one southern white physician noted:

> . . .the differences in the organic or physical characters imprinted by the hand of nature on the two races [made it obvious] that the same medical treatment which would benefit or cure a white man, would often injure or kill a Negro. . .[10]

In addition, slaves were an available source for physicians wanting to further their medical education; an abundance of material in the southern medical journals reveals that slaves were used in significant numbers for medical experimentation and demonstration.[11]

In response, slaves were reluctant to report illnesses to their masters, relying instead on home remedies and Negro herb and root doctors. A concealed illness did not entitle the slave to any time off, so most slaves continued working while sick, often causing minor maladies to develop into serious conditions. Masters did not look kindly on slaves who disobeyed rules and took medical care into their own hands. A reluctance to

surrender their bodies to white medicine often resulted in harsh punishment, serious illness, or death.

The black experience with medical care changed drastically during the period immediately following the Civil War. Hundreds of thousands of newly emancipated blacks stood in dire need of medical care and economic assistance. Local authorities generally refused to appropriate money for black health facilities, and most white doctors did not treat black patients unless paid in cash. Traditional healers gained in popularity but could do very little to control smallpox, yellow fever, and cholera.

The Freedmen's Bureau, established by Congress to care for recently freed blacks, was the only systematic response to this health crisis. Plagued by inadequate funding, a shortage of hospital beds, and a lack of facilities in the rural areas where most blacks lived, the Freedmen's Bureau nonetheless managed to treat an estimated half million former slaves.[12] Subsequently, the death rate among the freedmen was reduced from 30% to 13% in 1865 and to 2.03% in 1869.[13] These figures reflect rapid intervention by the federal government during Reconstruction; they do not indicate any advances in medical technology or better treatment by the medical profession. It is even possible that these statistics were manipulated so as to secure continued funding from the government. Physicians' perceptions and practices had not changed; any improvements in black health status were short-term and directly related to Congressional activity.

SEGREGATION

> The average death-rate of the Negro population in this little city of about 10 000 souls [Selma, Alabama] is little less than 30 per mile, 50% of which, in my opinion, is due to bad sanitation, gross neglect of the simplest laws of hygiene, and general ignorance of results.[14]

The views held by this physician, Dr F. Tipton, are characteristic of an ideology espoused by both the medical community and southern society as a whole. By the late 1890s, codification of segregation was adopted in almost all southern states. Justification for this separation of the races has been explained in medical terms by prominent southern physicians: blacks were considered pathologically different from whites, unfit for freedom, and uneducable in the ways of better hygiene.[15] White supremacists could not possibly share train cars, water fountains, or hospital wings with "unclean" Negroes.

The vital statistics illustrate the consequences of contemporary issues: in 1929, the infant mortality rate for the southern black population was 98.4 (per thousand), while for whites it was 60.2.[3] Contributing to high mortality were poor housing, inadequate nutrition, severe working conditions, and lack of proper medical care. The blame for each of these factors was invariably placed on the victim. As Dr Tipton points out:

> His [the Negro] diet is fatty; he revels in fat; every pore of his sleek, contented face wreaks with unctuousness. To him the force-producing quality of the fats has the seductive fascination that opium leaves about the Oriental. . .[14]

The opinion of most physicians was that it was futile even to try to rescue blacks' health. They felt that high mortality was a natural consequence of being black and could not be influenced by medical intervention.[15]

In an attempt to combat discrimination in terms of both health care and education, black and white philanthropists, with some help from the federal government, began establishing black medical schools. Between 1869 and 1900, 11 medical schools were founded for the sole purpose of training black physicians. By 1901, only seven of these schools remained. In 1910, the Flexner Report on medical education closed five more schools, terming them "ineffectual."[16] Only Howard University College of Medicine in Washington, DC and Meharry Medical College in Nashville survived the ultimate judgment of the Report. For all practical purposes, these institutions were the only places open to blacks seeking a medical education. Most white schools in the North and West admitted black students, but on a quota basis. Consequently, prior to World War II, these programs produced fewer than 20 black physicians each year.[15]

Unfortunately, medical aptitude, as measured by the Board of Medical Examiners, of the average graduate from the black medical schools was poor: between 1902 and 1946 an average of 54% of Meharry's graduates and 26% of Howard's failed their medical boards.[15] Reasons for this poor performance had little to do with the ability of the students or the quality of teaching. Rather, inadequate undergraduate preparation, insufficient educational resources, and exclusion from practicing at most medical facilities contributed to the black medical student's lack of success. In addition, because the exams were prepared by white physicians for typical white medical students, one must consider the racial bias of the questions when analyzing failure rates.

Black students who overcame the obstacles found a new set of barriers when they attempted to practice medicine. Very few hospitals granted admitting privileges to black physicians, and those that did forced them to work under substandard conditions. Their problems were compounded by the fact that even black patients considered black physicians inferior to their white colleagues. Blacks often rejected black doctors, either insisting on more expensive and less accessible white physicians or foregoing medical treatment altogether. Perhaps the greatest obstacle facing black physicians, however, was their exclusion from the AMA.

Until 1965, the AMA supported policies that systematically discriminated against black doctors. Many white physicians, primarily from the North, recognized the effect of these policies and attempted to change them through Resolutions in the *Journal of the American Medical Association:*

> South of the Mason and Dixon line, Negro physicians are generally, and systematically excluded from membership in county medical societies, making membership in the American Medical Association and affiliation with organized medicine impossible.[17]

The response to this Resolution appears later in the same issue of the Journal.

> . . .it [the resolution] does set up policy. In doing that, the resolution implies that the county medical societies should not, in effect, have the right of selection of its own members, a fundamental principle in our organization. Readjustment along the lines of the resolution are rapidly taking place in those states most vitally interested. Your reference committee recommends that the resolution be not passed.[18]

Apparently, the AMA did not believe that it had any role in race relations and therefore continued to allow discrimination to occur for another three decades. Doctors, who had chosen a career dedicated to maintaining the well-being of people, were methodically damaging the health of one very large group.

The health of blacks in the South was greatly affected by the white medical community. In the same volume of the *Journal* that refused to end discrimination against black doctors was an article written by the Mississippi State Board of Health. One table of figures, in an extremely biased report, stands out. It depicts the number of patients dying without medical care in Mississippi for the years 1933 through 1937. In 1933, 3543 "coloreds" died without medical care, while only 461 whites were counted in that category. By 1937, these numbers were 3191 and 531, respectively.[19] Because blacks represented 50% of the population at that time, these figures are indicative of a discriminatory health-care system. The article continues by addressing some of the reasons why the figure for whites is so high, completely ignoring the statistics for black patients.

White doctors were responsible, to a large degree, for these staggering differences between the health care given to whites and blacks. By refusing to treat black patients, white doctors were denying that population the benefit of newly discovered medications, treatments, and preventive services. Black practitioners found it difficult to alleviate the health problems of the black community. Black physicians were rendered less effective in their treatment of patients by two factors. First, exclusion from the AMA limited their access to new techniques and denied them a forum for exchanging ideas with the entire medical community. Second, many blacks were aware of the inferior training given to black physicians and were therefore hesitant to solicit their services. This situation was compounded by the lack of respect—by both white and black populations—accorded all black professionals in the South, regardless of their education.

The discrimination black patients experienced while in the hospital also had a great effect on health status. White physicians contributed to Jim Crow by perpetuating segregation in health-care facilities. Only Mississippi and South Carolina specifically provided by law for general segregation in hospitals. Nonetheless, segregation was the rule in hospitals throughout the South.[20] It is apparent that physicians, usually the most influential group in the hospital, accepted separation of the races and stood by while millions of blacks were mistreated and denied essential care.

> This section [the black wing of the hospital] was usually the poorest and worst situated of any in the hospital and frequently the service was on par with the location.[21]

Vital statistics for blacks who received medical treatment under a Jim Crow system were far worse than for those who were not subjected to segregation in the hospital:

> There is no question that if the same care were available to Negroes in Mississippi and other southern states as in Minnesota and other northern states, Negro morbidity and mortality could be sharply reduced. Factors

> responsible for this difference are poverty, lack of Negro doctors and of doctors for Negroes and the exclusion of Negroes from first-class "white" hospitals.[22]

In the 1950s, area hospitals in Birmingham, Alabama allocated 1762 beds to whites and 574 to blacks, although about 40% of the population was black. In Baltimore, Maryland, in 1959, 70% of all black births were delivered in seven of the 17 hospitals because only those seven offered accommodations to black patients.[22] One reason why hospitals did not feel compelled to provide services for black patients in their "white" facilities was because federal legislation supported this discrimination. The Hill-Burton Act of 1946, designed to improve the hospital bed-to-population ratio in rural areas, operated under the "separate but equal" principle. Federal funds were used to create more than 1 million beds, many of which were denied to black patients. Dr Max Seham sums up the effect this program had on the black population:

> Ironically, in spite of the fact that the Hill-Burton Act has proved to be the nation's largest investor in hospitals, the "separate-but-equal" clause has become a Dr Jekyll to the "whites" and a cruel Mr Hyde to the Negroes. To 20 000 000 citizens, discrimination and segregation followed.[22]

In 1964, after almost 4 years of attacks on federal government policies by the National Association for the Advancement of Colored People, and 14 years after *Brown v. Board of Education,* there was still one "separate-but-equal" project approved.[22]

Black physicians recognized the damage discrimination was doing to the black population and to their own abilities as providers of quality medical care. Unfortunately, their exclusion from the AMA and most hospitals rendered them virtually powerless. In an effort to make themselves equal to white physicians in terms of education, professional affiliations, and prestige, black physicians formed the Tuskegee, Alabama-based National Medical Association (NMA) in 1908. At its inception, the NMA attempted to focus more on the education of its members and its acceptance in the broader medical community than on the health of the black population. Attainment of these early goals was necessary before any widespread problems could be tackled. Dr A.M. Townshend, the first president of the NMA, delineated these goals in his President's Address:

> Our object, as I see it, is first to help ourselves and second to help others. . .To teach our people the importance of patronizing and having confidence in Negro physicians. To teach them that it is to their interest when sick to send for Negro doctors and to go to Negro hospitals where their infirmities may be treated.[23]

The National Hospital Association (NHA) was organized in 1923 as a constituent member of the NMA. The purpose of the organization was "to bring to bear all the forces possible in combating the unfavorable conditions existing relating to our hospitals, practicing physicians, interns, and nurses."[24] Black physicians were denied access to most southern hospitals and "year by year more states were added to [the] list of those requiring internship in a recognized hospital as necessary for a license to practice medicine."[24] The work of the NHA in meeting its objectives was called the "Great Awakening" by Dr John A. Kenney and other prominent black physicians:

> Seven years ago we had only four class 'A' hospitals giving fifth year medical training to Negro interns, while now we have interns in 16 hospitals, 12 of which have their 'A' class rating and the others are conditionally accepted.[21]

The battle for equality in the southern health-care system was a microcosm of the battles taking place across the United States. The work of black physicians, in their struggle for equality in medical schools and hospitals, and in their fight for improvements in the health status of the black population, paralleled the work of other civil rights activists. By the 1930s, the *Journal of the National Medical Association* became more than an educational reference for black physicians; it blossomed into a forum for discussions about discrimination. Each volume supplied physicians with news about current political activities and articles focused on integration. In 1930, the *Journal* advertised "National Negro Health Week," a movement first fostered by Booker T. Washington. The article was a call to arms:

> Negroes everywhere are asked to participate. No one is too large or too small to take part. There is no national movement that offers such far-reaching opportunities and results, and in which all may work in common. . .in the improvement of the health and living conditions of the colored people of the United States, and thus a reduction in their mortality.[25]

In 1931, the *Journal* reported on a conference of health and welfare workers, held in Washington, DC, to

"consider ways and means of controlling the high mortality of colored people in rural communities and congested cities."[26] The participants discussed Negro Health Week and decided it "had done much good in teaching the Negroes habits of better living."[26] Perhaps it would be more accurate to say that Negro Health Week helped teach blacks to survive in a segregated, racist society. The movement provided blacks the opportunity to band together against apartheid; it offered blacks the chance to improve their health status, against the odds.[27]

Black physicians vocalized their opinions through a multimedia campaign, using newspapers, magazines, and radio to broadcast their message. Unfortunately, these messages were heard mainly in the North, where, although segregation was an issue, most white physicians were already taking an active role in black health care. In 1931, Dr John A. Kenney chaired a meeting of the Inter-Racial Committee of Montclair, New Jersey, after which he broadcast highlights from the meeting on a local radio station. The object of the committee was:

> To show that there is inadequate hospital provision for the Negro race. . .That this is partially responsible for the high morbidity and mortality rates among us. . .That there is in some form, in practically all sections, discrimination against patients of the Negro race, and more extensive discrimination against the Negro medical profession.[28]

In his speech, Dr Kenney admitted that blacks often had to give in to racist policies set up by the white medical community. "In the south the question settles itself. For the next century at least, it is the Negro hospitals or none."[28] This realization emphasizes the fact that blacks needed to survive first and fight second. A weak, unhealthy population cannot fight a war.

For three and a half decades (1930 to 1965), black physicians were actively fighting for an equitable health-care system. Their target was, primarily, the white medical community. Black physicians realized they must attack slowly, first trying to elicit some respect from white physicians. In 1930, a letter was written to the editor of the *Journal of the American Medical Association* by a black physician, asking that the letter "N" in Negro be capitalized in all publications of the *Journal:*

> To you it may be merely a typographical change, a mechanical adjustment, but to the millions of Negro folk and the thousands of Negro medical men, who believe in the principles that the American Medical Association stands for, it is "an act in recognition of racial self respect for those who have been in the 'lower-case' so long."[29]

Morris Fishbein, the editor of the *Journal of the American Medical Association*, agreed "to use the capital 'N' when referring to the Negro in the ethnological sense."[29] In principle, this correspondence was very meaningful to the black community, but in reality, the word "Negro" appeared so infrequently in the *Journal of the American Medical Association*—white physicians did not write very often about black health issues—that the victory was not nearly as sweet as it seems.

In September, 1938, representatives of the NMA appeared before the Board of Trustees and the House of Delegates of the AMA to ask for aid in securing recognition of black physicians by agencies of the federal and state governments. In addition, the NMA expressed the desire to have the designation "col," which appeared with the names of black physicians listed in the American Medical Directory, removed. In response to the first request, the NMA delegates were referred to a special "reference committee" of the AMA; in response to the second request, the AMA stated that it "will undertake to work out some method for listing Negro physicians in the American Medical Directory in a manner that will not be objectionable to them."[30] In other words, black physicians would continue to be singled out, indicating their lack of equality and the lack of respect given to them by the white medical community. The AMA persisted in its discrimination against black doctors and continued to place black health issues "on the back burner" until forced to do otherwise by legal sanction.

In the mid-1950s, the *Journal of the National Medical Association* began featuring a section entitled "Integration Battlefront." On the pages dedicated to integration issues, black physicians enlightened one another on integration activities that were taking place nationwide. Amongst these news items were updates of petitions against the AMA. One such article reported on the Washington State Medical Association Petition to AMA Against Discrimination. In it, Washington physicians petitioned the AMA to:

> Call to the attention of its members their obligation and responsibility under Chapter 1, Section 2, 1955 Principles of Medical Ethics, which implies that medical and hospital facilities, if available, be open to all persons and that all physicians be permitted to practice their skills dependent upon their professional qualifications only.[31]

Although this petition attempted to eliminate segregation, its emphasis on abiding by the Principles of Medical Ethics provided an opportunity for discrimination to persist. The Principle did not address the need for medical personnel and facilities in predominantly black communities, and its emphasis on qualifications had a large effect on the number of practicing black physicians. It discriminated against black doctors because their training was not on par with the rest of the medical community, but it did nothing to provide blacks with better educational opportunities.

Many black physicians attempted to elicit the help of the American Public Health Association (APHA) in their fight against discrimination. Paul Cornely, a graduate of Howard University, was the impetus behind the activities supported by the APHA. He insisted that "the destructive effect of segregation and discrimination was no longer in doubt: they are environmental factors and are just as damaging to health as water pollution, unpasteurized milk, or smog."[32] The mainstream medical and hospital associations were not under the jurisdiction of the sympathetic APHA and needed to be attacked by a stronger political campaign. The Imhotep (from the Greek for "he cometh in peace") Conferences of 1957 to 1963 were national meetings launched by Cornely and his colleague W. Montague Cobb that sought to assemble white and black physicians and hospital administrators for face-to-face discussions on hospital segregation. The Conferences reflected the hope that integration could be achieved voluntarily, without divisive court and legislative battles. Cornely and Cobb believed that even if friendly persuasion did not move the white establishment, the Conferences would provide a forum for blacks to present their grievances. It was quickly clear that the forum was all Imhotep would provide; not a single white medical or hospital association—not even Catholic or Protestant hospital associations—sent delegates to the initial 1957 sessions. The AMA sent only an observer.[32]

When, in the 1960s, the first integration activities of the AMA and AHA began to occur, only readers of the *Journal of the National Medical Association* learned of them. Readers of the *Journal of the American Medical Association,* on the other hand, were ill-informed about Civil Rights activities taking place in the health-care system. In fact, the AMA's reaffirmation that it "will continue to use all of its influence to end discriminatory racial exclusion policies or practices by any medical societies which permit such policies or practices to exist" was not found in the *Journal of the American Medical Association* but in the *AMA News,* a publication with far fewer subscribers.[33]

The Civil Rights Act of 1964 outlawed the activities that had been considered "criminal" by the black population for more than a century. Although it was no longer legal for white physicians to discriminate against black patients and physicians, subtle discrimination continued. In 1965, the Health, Education, and Welfare Department said it was not necessary for individual physicians to sign nondiscrimination pledges to receive payment for handling federal-state welfare patients. The reason for this proclamation was that some state health departments interpreted the Civil Rights Act as requiring physicians to sign compliance statements that services would be rendered "without discrimination." Some state societies and individual physicians protested that signing such a pledge would interfere with physicians' ethical rights to accept patients on an individual basis and would constitute a federal interference in the patient-physician relationship.[34] In other words, doctors did not want to lose their right to refuse patients on the basis of inability to pay for services. Since the majority of black patients fell into this category, physicians were attempting to disguise racism in economic terms. This is the type of de facto discrimination that persists throughout the United States.

THE CURRENT SITUATION

The health status of blacks in rural communities and congested urban centers in the United States in 1992 is often compared to the health status of Third World populations. The persistence of racism in American society, and especially within the health-care system, is the primary reason why the health of black Americans is so vastly different from the health of the white population in the United States. The covert racism that exists in many institutions today is manifested in a number of ways, most often in the adoption, administration, and implementation of policies for the poor. Many rules and regulations governing the present health-care system discriminate in the quality of care provided to the poor. Institutional views toward the treatment of the poor overlap their attitudes toward blacks. Overt racism is evident in many of the observable practices of health-care institutions: admission practices of hospitals, bed assignments, and the assignment of physicians.[5] These practices provoke blacks to seek care outside the institution, with consequences that resemble those discussed earlier for slaves who refused to submit their bodies and souls to a white health-care system.

Blacks often go without treatment or rely on the emergency room for primary care.

Access to health care has always been a problem faced by black Americans. Whether access is denied by legal segregation or the manifestations of inequalities in politics and economics, the result remains the same. In 1930, the *Journal of the National Medical Association* published an article entitled "Health Statistics in Harlem."[35] In 1990, *The New England Journal of Medicine* published an article entitled "Excess Mortality in Harlem."[4] The similarities in the vital statistics provided by each author are frightening—with all the medical advances made during that 50-year period, the mortality rate for blacks in Harlem remains more than 40% higher than the New York City average.[4]

CONCLUSION

The white medical community has played a large role in improving the health status of the white population. In contrast, the black population has suffered under the control of white physicians. Black doctors and patients have systematically been discriminated against by white health-care providers. The activities undertaken and the ideology espoused by the AMA have had devastating consequences on the health care delivered to blacks. Dr Victor C. Vaughan, III, a white physician who practiced in the South during the 1960s, calls the activities of the AMA "undeserving of respect." He recalls proposing in 1963 that the Richmond County Medical Society of Georgia allow a black doctor to join their ranks. The discussion that ensued included talk about the possibility of creating a new category for black doctors that could keep them segregated within the larger Medical Society. Also, the consequences of any relationship between the black doctor's wife and the existing Women's Auxiliary were discussed in detail. A verbal vote resulted in the acceptance of the black physician, but Dr Vaughan's memory of the racism that dictated those discussions still evokes a "feeling of disgust" (Victor C. Vaughan, III, MD, April 20, 1990).

As reflected in the current vital statistics for blacks in the United States, legal mandates have not been enough to combat the effects of racism. Institutions run primarily by white physicians continue to support racist activities. Only through education and persistence can Americans hope to change the current system and mold future generations.

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