Current Clinical Psychiatry
Series Editor: Jerrold F. Rosenbaum

Morgan M. Medlock
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David R. Williams *Editors*

Racism and Psychiatry

Contemporary Issues and Interventions

Humana Press

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To Professor Chester M. Pierce

He mentored many of us and taught us much about the inherent dignity of men and women. He helped us avoid defensive, apologetic thinking and urged us to help transform our communities into therapeutic spaces.

Foreword

> The most difficult social problem in the matter of Negro health is the peculiar attitude of the nation toward the well-being of the race. There have been few other cases in the history of civilized peoples where human suffering has been viewed with such peculiar indifference.
>
> —W.E.B. Du Bois (1899)

It is a humbling experience to be asked to write the foreword for this book. On the one hand, as the first African American elected to hold the office of president in the 174-year history of the world's oldest psychiatric organization, I am honored to receive the invitation. On the other hand, it seems that we are still fighting the same battle described by Du Bois over a century ago, regarding understanding and incorporating the unique cultural differences encountered at the intersection of race and health care, including psychiatry, into treatment approaches. The need for this book, however, cannot be underestimated, given the current challenges facing both the increasingly diverse population of the USA and the field of psychiatry.

However, Du Bois could not have imagined that over 100 years after he made the above statement, we would still be sorting out this "social problem." And, although he was not a behavioral health professional, in that one statement he provided a critical analysis of a situation about which much has been written in the intervening years: race and racism as social determinants of health and mental health; the impact of both on access, diagnosis, and treatment for diverse racial and ethnic populations; and how these influence training and clinical care. Unfortunately, there remain gaps in our understanding of the cultural and social contexts of individuals from minority groups, which are significant determinants for clinicians and patients as they encounter each other in therapeutic situations. Along with the larger social issues of poverty, discrimination, and racism, these cultural factors often lead to misunderstandings and result in mistrust, bias, and poor outcomes for those who seek mental health services. Additionally, American psychiatry was founded on the principles of European medicine, "emphasizing objective evidence based on scientific inquiry" [1]. This foundation has resulted in gaps in understanding and awareness of the needs of nonwhite populations seeking psychiatric services.

It is a personal privilege to reflect on the work done by those who are part of the history of this issue and participate in the work being done by the next generation of clinicians and scholars in this area. In fact, the title of this book immediately

reminded me of a book with a similar title published about 45 years ago—*Racism and Psychiatry,* authored by Drs. Alexander Thomas and Samuel Sillen [2]. They reviewed the impact of historical and contemporary racist thinking on psychiatric diagnostic formulation, addressing the myths and stereotypes of the day. The foreword was written by Dr. Kenneth Clark, best known for his landmark doll test study of "race, color and status on the self-esteem of children." Their work is an early example of a social justice approach to psychiatric training, services, and advocacy, cited in the *Brown v. Board of Education* case when it was heard before the US Supreme Court in 1954.

From the earliest days of psychiatry in America, psychiatrists have struggled with how to deal with racism, which is at the core of relations between blacks and whites in this country. From Samuel Cartwright and *drapetomania* (a "disease" causing blacks to have an uncontrollable urge to run away from their masters) to Benjamin Rush and *negritude* (a rare, congenital "disease," which derived from leprosy and entitled blacks to a double portion of humanity from whites), the field has struggled to understand, within the context of racial and ethnic differences, how to understand and provide treatment to African Americans with mental illness. The 13 founding members of the American Psychiatric Association (which started as the Association of Medical Superintendents of American Institutions for the Insane, then became the American Medico-Psychological Association), at an early organizing meeting, established a "Committee on Asylums for Colored Persons," which may represent the first effort to address the race problem in psychiatry. The history of psychiatry is filled with many stories of the challenges raised—many still unaddressed—as it relates to American psychiatry and African Americans. Over the last 50 years, this history has been chronicled in many different ways. Numerous books, articles (in scientific and lay journals), conferences, and other modes of communication have raised questions regarding racism as a mental illness and the continued racial and ethnic disparities in the clinical arena. Misdiagnosis and research outcomes that result in inadequate and inappropriate treatment for blacks continue to concern many in the African-American community.

In 1970, Sabshin et al. [3] wrote about racism and psychiatry in the *American Journal of Psychiatry*: "We can no longer pretend it does not exist in psychiatry; we must counter our earlier denial with a hyperawareness that we hope will be temporary during a period of transition. Our own openness and effort can encourage other professional groups to also bring the efforts to combat white racism out of the shadows to the center stage of everyday life where this struggle belongs—if racism is to be eradicated." Unfortunately, the estrangement has continued, affecting training, research, and clinical practices, and resulting in a significant disparity in mental health access and treatment.

Understanding the evolution of psychiatry and psychiatric practices in the USA and how it has impacted the health and emotional well-being of African Americans over that same time period is critical to understanding this book's proposed framework for solutions. This millennial-led team has tackled the tough topics, picking up where the 2001 Surgeon General's report *Mental Health: Culture, Race, and Ethnicity* left off [1].

Their approach to discussing and addressing these race-related issues gives hope that perhaps we have reached a point in the relationship between blacks and whites

in psychiatry where we can address these issues and move forward in our understanding of how to eliminate disparities and develop strategies for improving the awareness and utilization of psychiatric services by all marginalized groups.

It is significant that the book includes chapters on training and advocacy issues, broadening training to include the incorporation of innovative didactic and experiential examples into the medical education curriculum. The Massachusetts General Hospital (MGH) model is provided as one example of how academic medicine can begin addressing the issues of racism within interpersonal and institutional settings. Its early recognition of the importance of training for faculty and supervisors shows promise for moving beyond earlier efforts in cultural competence training that often did not include these individuals, and therefore left medical students and residents exposed to these concepts and values without solid support within the medical hierarchy. This work is essential to efforts to improve diversity in the psychiatric workforce and promote health equity for marginalized populations.

Racism and Psychiatry: Contemporary Issues and Interventions is an excellent contribution to a growing body of work at the intersection of psychiatry, the cultural context, and health equity. Dr. Medlock, her distinguished colleagues, and the contributing authors are to be commended for the excellent job they have done to bring these issues to the forefront in our field. This volume provides an excellent picture of what can happen to create a paradigm shift when a diverse group of highly motivated and social justice–driven individuals tackle long-standing and difficult issues, whether in society or in our profession.

I keep images of other "first" blacks in medicine—Rebecca Lee Crumpler, Rebecca Cole, Susan McKinney Steward, and, of course, Solomon Carter Fuller—with me at all times as reminders of the work done by others and to encourage me to keep moving forward. It is my hope that this volume will be that reminder for other health professionals well into the future.

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Introduction

Racism is defined as "a system of structuring opportunity and assigning value based on the social interpretation of how one looks [1]." Since the very public shooting of Trayvon Martin in 2012, followed by a never-ending stream of black deaths at the hands of white police, to the President's neutrality over a racist-driven rally in Charlottesville, Virginia, to actions of the Supreme Court and of the Justice Department to eliminate voting protections and reinstate draconian sentencing policies that disproportionately affect men of color—there has been a pressing national conversation about racism and the treatment of black people in the United States, from the period of slavery to modernity. Concurrently, psychiatric trainees and the community psychiatry faculty at Massachusetts General Hospital (MGH) began to address the dearth of formal didactic content exploring the mental health impact of racism on African Americans, a topic that seemed inadequately addressed by standard cultural competency curricula. Shortly thereafter, an anti-racism didactic curriculum was formulated [2], which focused on the levels of racism that intersected, and often disrupted, the mental well-being of African Americans. Entitled "Racism, Justice, and Community Mental Health," this required didactic curriculum engaged psychiatric trainees at all levels with topics ranging from residential segregation and its impact on mental health access and outcomes to personally mediated racism and the clinical encounter. Over 60 trainees participated during the first year, and most of them felt that training that moved beyond cultural competency to directly address racism and its effects on African Americans, specifically, was not only worthwhile, but critical to the practice of psychiatry.

Developing an anti-racism focus in psychiatric training raises additional questions about the role of mental health treatment in the lives of oppressed people. What comprises "treatment" for communities of color, which are marginalized by bias and racism that is structurally embedded in systems of housing, education, and law enforcement? This book is the culmination of our grappling with such questions and desiring to understand and tell a story—though imperfectly—about historical oppression, present-day racism, and potential ways of understanding and intervening in a therapeutic manner when working with individuals and communities whose experiences are inevitably shaped by failures in equity. We also make visible the ways in which the medical profession generally—and organized psychiatry in particular—have reproduced racial inequities in access to care, diagnosis, and treatment. Though we recognize that diverse communities have been impacted by

racism, our focus is on the African-American narrative, both to allow for sufficient depth in the discussion and to appreciate the nuanced historical elements of trafficking and enslavement, as well as to understand the communities' subjection to modern versions of anti-black racism. Where possible, we expand the conversation to the experiences of other racial groups in the United States, including Latinx, Native American, and Asian populations.

We understand racism as a three-tiered construct that operates on institutional, interpersonal, and internal levels [3]. Institutional racism creates 'differential access to the goods, services, and opportunities of society', by the social construct of "race." An example of institutional racism is the reduced access to medical care and over-representation in the penal system for African Americans. Interpersonal racism is the driving force behind race-based assumptions about the abilities, motives, and intentions of others. It can lead to feelings of suspicion toward or lack of respect for the other, as well as contribute to blatant acts of discrimination, such as police brutality and hate crimes. Internal racism refers to the negative psychological impact of racism upon the members of a stigmatized race. This can manifest as self-devaluation, resignation, and hopelessness.

With this framework in mind, we have organized the book into three sections. The first section lays the historical foundation for anti-black institutional racism in America, beginning with the institution of slavery. Chapter 1 explains how racism intersected with organized medicine and psychiatry, providing a critique of how physicians and health professional organizations have both contributed to and challenged racist ideologies in society. Chapter 2 builds upon this discussion by examining the impact of historical racism-mediated traumas on the internal functioning of African Americans. The chapter is balanced by a discussion of strategies for building capacity and coping among individuals with a lived experience in dealing with racism and discrimination.

The second section of the book moves from a discussion of the historical legacy of slavery to contemporary issues—including residential segregation, homelessness, and mass incarceration—and how these issues affect mental health and access to treatment for mental health problems. Chapter 3 helps readers decipher the complex literature on racial/ethnic segregation and its impact on mental health and access to services. The protective effects of living within ethnic communities are explored, along with the negative consequences that result from a concentration of social factors (e.g., poverty) that target a "race" of individuals. The latter consequences are a direct result of institutional racism. Chapter 4 continues with a discussion of housing by exploring homelessness and its disproportionate impact on African Americans. The chapter offers significant depth and perspective on how this problem developed, but also suggests multiple approaches to achieving housing equity—a critical factor for achieving health overall—through practice, policy, and research.

Chapter 5 turns the discussion to what is colloquially known as "The New Jim Crow" [4]—a system of targeted policing and incarceration of racial minorities. A plethora of issues related to the criminal justice system are explored, including the shift from hospital-based to jail- and prison-based mental health treatment since the 1960s, as well as the punitive approach taken to addressing substance use disorders

in minority communities versus medical approaches to addressing those same issues in white communities. Consistent with the focus of the entire book, the chapter does not end with naming problems, but ends with exploring solutions. Here, the authors explore strategies for changing the criminal justice system's treatment of individuals with mental health disorders, from the initial point of crisis to community reentry. Solutions that can change the conversation and trajectory—from one of punishment and discrimination to one of treatment and rehabilitation—are the focus.

Chapters 6 and 7 explore interpersonal racism within the clinical encounter. Chapter 6 begins by recounting the tragic narratives of the police shootings of Jordan Edwards, Philando Castile, Tamir Rice, and Trayvon Martin, among other narratives of the mistreatment of unarmed black Americans by officers and civilians. This background is used to support the chapter's central conclusion, i.e., that the black body represents a *phobogenic object* [5] in white American society. The dynamics uncovered when an individual whose body is the source of *object fear* [6] presents for therapy are explored through the case discussions of two black men. The chapter also explores racism-related material that may arise in treatment, through a case discussion of a white client who seeks help from a black therapist. Chapter 7 continues the discussion of interpersonal dynamics in treatment by offering a comprehensive review of the causes and manifestations of bias in the diagnosis and treatment of African Americans and other racial minorities. This review guides clinicians with recommendations for achieving equity in their prescribing and psychotherapy practice.

The final section of the book provides strategies for the clinical engagement of individuals who are coping with and overcoming the systemic, interpersonal, and internal effects of racism. Chapter 8 discusses the role of the black church [7] in the lives of African Americans, the most religiously involved racial group in the United States. The Christian church presents the gospel of Jesus Christ, which bestows freedom and a transformed identity. The church is also a critical channel of hope and resilience for African Americans through its worship, counseling, and support functions. The chapter challenges clinicians to consider interventions that boldly address the spiritual concerns of clients along with their clinical presentations. Integrating spirituality into treatment is one strategy for addressing cultural mistrust, and Chapter 9 advances the discussion by considering a range of interventions that can strengthen the rapport and alliance between providers and clients with experiences of racism and discrimination.

Chapters 10, 11, and 12 consider the structural changes that must take place within Psychiatry if the field is to move toward equity. Chapter 10 acknowledges the glaring need for more providers of color and suggests strategies for recruiting and retaining individuals from minority backgrounds. Chapter 11 considers the profound gaps that exist within medical education, where issues of racism and privilege are rarely named or are inadequately addressed through cultural competency curricula. The need to move beyond these conversations in training to develop and implement anti-racism and structural competency curricula is acknowledged and explored through the discussion of specific examples and approaches. Chapter 12 considers

the role of the mental health provider as an advocate for racial/ethnic minorities. Policy and political approaches, along with clinical and research interventions for achieving behavioral health equity are explored.

The final chapter returns to the interpersonal and internal lenses for understanding racism-related experiences. It is a clinical toolkit that contains a medley of approaches that we hope will foster creativity and broaden the discussions around race and identity in psychotherapy.

We humbly submit this book to readers as an effort to highlight contemporary conversations about racism in a formal psychiatric text. In completing this work, we were guided by the ideas of many who have devoted their careers to bringing concerns about racism and its consequences to the forefront of academic psychiatry. We hope that readers will be inspired not only to join the long list of individuals who take an interest in dismantling racism but also to take the actions necessary to move us forward. We hope that this text will be useful in developing anti-racism curricula across the country. As conversations bloom, we look forward to seeing change.

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Part I

Historical Context

Origins of Racism in American Medicine and Psychiatry

1

Kimberly Gordon-Achebe, Danielle R. Hairston, Shadé Miller, Rupinder Legha, and Steven Starks

Introduction

Modern-day commentary on the history of racial oppression in America often highlights the social and political atmosphere of slavery from its inception in 1619. Much has been written on the evolution of these injustices—the Civil War, the Black Codes, the Reconstruction period, the Jim Crow laws, and White Nationalism—and the resistance movements that have countered them (e.g., the Abolitionist, Civil Rights, Liberation, and #BlackLivesMatter movements) [1–3]. Overarching themes of racism frame certain spheres in society. Critiques of the criminal justice, housing, education, financial, and health care systems typically review inherent disparities that persist for black Americans [4–9].

In most cases, analyses of disparities in health care and medical practice skirt the origin and historical impact of attitudes and policies within organized medicine.

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Medicine, at its core, is a noble and ethical helping profession, so difficulty arises with self-condemnation.

However, several practices within organized medicine and psychiatry have perpetuated inadequate care for black patients. They include limitations on the influence of black physicians and stymying of the research needed to enhance black Americans' health; promotion of unscientific, unethical, and unjust medical research and clinical practices; and support for policies that have further marginalized blacks. The prevailing sociopolitical and economic realities of blacks have created racialized mental health disparities. The consequences of these practices have been service disengagement, pervasive mistrust in medical care and research, and nonideal pathways to care (e.g., school-to-prison pathways, involuntary psychiatric hospitalizations, and care in child welfare and correctional settings) [10–12].

American Colonization and Slavery

The impacts of racism and racial stratification on the mental health of blacks in the USA extend as far back as the 1600s. From the beginning, enslaved blacks were aware that their only options were to "submit or die" [13]. Each day consisted of an assault on their autonomy. To survive, the enslaved had to submit. They were punished for being defiant, mature, or independent. They could not express themselves. "[The slave] must, in fact, learn to treat himself as chattel, his body and person as valuable only as the owner placed value on them. He must learn to fear and exalt the owner and to hate himself" [13].

The enslaved could not adopt a healthy sense of self-esteem or invest in themselves. The institution of slavery rendered blacks powerless and scarred mentally. This loss of autonomy resulted in the inability to express feelings. Because of racial terrorism, slaves learned to suppress their anger. Suppression of anger became a survival strategy and frequently saved them from a quick and horrendous death [14]. Presently, these effects are seen clinically and broadly in society. In treatment settings, patients may suppress or deny anger and emotions. As Brown notes, these denials become normative: "false affability, passivity, resignation, and ultimately withdrawal or inward self-destruction" [14].

Defining Blackness: Illness and Inferiority

Benjamin Rush, MD, a signer of the Declaration of Independence and often heralded as the "Father of American Psychiatry," defined "negritude" as a mild form of leprosy that could be cured only by becoming white [15]. Despite the observation by Rush (a cofounder of America's first antislavery society in America) that Africans appeared to become insane after entering slavery in the West Indies, his medical terminology was used to justify the inhumane treatment of enslaved blacks [16, 17].

Although Rush was against slavery, the disorder he defined was used to potentiate the cruel treatment of slaves [15–17].

Throughout US history, psychiatry has been used to validate slavery. The 1840 US Census claimed that enslaved blacks were free of mental illness: "The black man becomes prey to mental disturbances when he is set free" [12, 15, 17]. To support this claim, psychiatric professionals manufactured data suggesting that insanity rates increased in relation to a black person's proximity to the north. The further north they lived, the more insane they were likely to become [18]. These proslavery findings were challenged by Dr. James McCune Smith, the first black physician to earn a formal medical degree at the University of Glasgow in Europe. Smith wrote, "Freedom has not made us mad. It has strengthened our minds by throwing us upon our own resources" [19].

Samuel A. Cartwright, MD, a prominent Louisiana physician and a leader in the proslavery movement, coined the mental health disorder "drapetomania." Its symptoms (seen only among the enslaved) included the uncontrollable urge to escape, disobedience, talking back, and refusing to work [18]. Cartwright identified whipping as its therapy. He encouraged overseers and slave owners to keep the enslaved submissive and to treat them like children with "care, kindness, attention, and humanity, to prevent and cure them from running away" [15, 20]. He also diagnosed slaves with *dysaethesia aethiopica*, or rascality [15]. Cartwright chastised Northern physicians who "ignorantly attributed the symptoms to the debasing influence of slavery on the mind" [15, 20]. Theories of ethnogenetic vulnerability and inferiority, such as Cartwright's, were readily accepted and perpetuated white supremacy and racism in American culture [18, 21].

Dr. Cartwright was not alone in his oppressive psychiatric theories. James Woods Babcock, a psychiatrist and former superintendent of the South Carolina State Lunatic Asylum, used proslavery arguments to explain that Africans were "incapable of coping with civilized life" [12, 22, 23]. In his 1895 article "The Colored Insane," he attributed the "rapid increase of insanity in the negro" and the constant accumulation of black lunatics to emancipation [12]. In 1895, Dr. T.O. Powell, the superintendent of the Georgia Lunatic Asylum, reported that considering increasing rates of insanity after emancipation, the hygienic and structured conditions during slavery served as protective factors against consumption, a form of insanity [15, 24].

Scientific Racism

Scientific racial theories were developed in the eighteenth and nineteenth centuries in the USA and Europe. They emerged when imperialism and colonialism were prominent in European culture. In Benedict Augustin Morel's Theory of Degeneration, social conflict, aggression, insanity, and criminality were signs of regression to a racially primitive stage of development, which had physical and mental manifestations [12]. This tendency was said to lie dormant in white people. To Morel, *démence précoce* (schizophrenia) epitomized degeneration.

The scientists and evolutionists Jean-Baptiste Lamarck and Charles Darwin propagated the concept of degeneration by involving race thinking to explain "progress" [12]. In 1965, Sir Aubrey Lewis, the chair of London's Institute of Psychiatry, posited that non-Europeans were mentally degenerate because they lacked Western culture [12]. Aubrey Lewis became the foremost psychiatrist of the twentieth century in the UK. He transformed psychiatry in Great Britain and produced a generation of academic psychiatrists, and he was directly responsible for both shaping the Maudsley Hospital from its early beginnings and bringing about the existence of the Institute of Psychiatry as part of the University of London [12].

According to Lewis, blackness was equivalent to criminality and madness [12]. Cesare Lombroso, an Italian psychiatrist and the founder of the field of "criminal anthropology" in the 1890s, produced tables of photographs identifying physical features that characterized criminality and insanity. He believed that white races represented the triumph of the human species [12, 25]. He theorized that signs of criminality and madness that remained were primitive features of blackness. In *The White Man and the Coloured Man*, Lombroso wrote that only white people have reached the most perfect "symmetry of bodily form" and "freedom of thought" [25]. Carl Jung explained that many American negative traits were due to "living together with lower races, especially with Negroes" [26]. Stanley Hall, a psychologist, called Africans, Chinese, and Indians "adolescent races" [26]. An increase in insanity and other degeneracy that threatened the biological well-being of white American people was blamed on immigration [12, 27].

The concept of degeneration propagated crude theories of hereditable traits of criminality, feeblemindedness, and sexual deviance. American psychiatrists and physicians embraced theories to protect societal views and perpetuate racism. The aforementioned theorists pathologized cultural and racial differences—a pattern that persists. These physicians and scientists failed to analyze the impact of terror, familial disruption, isolation, and extreme poverty on health and perceived insanity among blacks. Exposing scientific racism is essential to protecting blacks from further psychiatric abuses and facilitating resolution of social, political, and economic problems [28, 29].

Twentieth-Century White Supremacy

The Eugenics Movement

A decade after the Civil War, the US Congress passed the Civil Rights Act of 1875, prohibiting discrimination in public places and, paradoxically, providing the foundation for the Jim Crow laws, which ensured separate and inferior treatment for blacks. The eugenics movement of the early 1900s bolstered whites' fears of integration and broadened concern about inheriting undesirable traits from blacks and other minorities. Across the country, social reformers, legislators, physicians, and medical superintendents joined forces to pass sterilization laws that eliminated what they perceived as negative traits (e.g., pauperism, mental disability, dwarfism,

promiscuity, and criminality) [30]. The legal ramifications of these efforts included immigration restrictions, interracial marriage bans, and forced sterilization. Unsurprisingly, these negative traits appeared concentrated in poor, uneducated, and minority populations [31].

Policies instituted between 1907 and 1940 resulted in 18,552 mentally ill persons being surgically sterilized [31]. Sterilization efforts initially focused on the disabled and later the poor. Sterilization advocates viewed reproductive surgery as a necessary public health intervention that protected society from deleterious genes and the social and economic cost of managing "degenerate stock" [30–32]. Certain laws stated that inmates of any state institution could be sterilized if the institution's board found the patient to be idiotic, insane, feebleminded, epileptic, or an imbecile. Sterilization programs found legal support in the Supreme Court case *Buck v. Bell* (1927), which set a legal precedent for sterilization of inmates of public institutions [32]. Thirty states adopted eugenic sterilization laws, which accounted for the forced sterilization of approximately 60,000 Americans. The extent of sterilization and its practices on minority populations, particularly black Americans, needs further research and investigation [33].

Eugenics influenced the passage of the Immigration Act of 1924, which limited the number of southern and eastern Europeans who could enter the country and prohibited immigrants from Asia; these policies remained in effect until the 1960s. In all of its parts, the most basic purpose of the 1924 Immigration Act was to preserve the ideal of U.S. homogeneity. Congress revised the Act in 1952. The 1930s marked a shift in forced sterilization, amplified by the atrocities of the Holocaust, committed against people of Jewish descent. Despite waning scientific and public support and the history of the human rights abuses of Nazi Germany, state-sponsored sterilizations in the United States continued long after the war. Sadly, its practice in the USA did not end until the 1970s [30, 31, 33, 34].

Understanding the role of American psychiatry in eugenics is complex. Hitler admittedly followed the laws of several American states, which allowed for prevention of reproduction of the "unfit," with the consequence that psychiatrists played a key role in the Jewish Holocaust [28, 35]. The *Journal of the American Medical Association* supported eugenics in its call for more robust science to explain mental disorders [31].

During the age of Progressivism (from the 1890s to the 1930s), American and Canadian psychiatrists made attempts to modernize their profession to attract medical trainees. Urbanization and the mixing of races stirred the conversations and anxieties of America [30, 31]. Since eugenics provided a theory for the inheritance of criminality, violence, sexual promiscuity, substance use, and intellectual inferiority, it resonated with psychiatrists who worked in state institutions for the "mentally handicapped."

Abraham Myerson, an American psychiatrist and neurologist, was arguably one of the most vocal opponents of eugenics of his time, yet he accepted aspects of the sterilization of the mentally disabled. He also advocated for more selective sterilization and spoke against Nazi eugenic law. While he acknowledged that there could be a heredity factor involved in mental illness, he also recognized that the social environment played a major role. He cautioned against the expectation that

sterilization programs would reduce the incidence of mental illness and radically affect the level of intelligence in society [33, 36].

Dowbiggin argues that despite the historical accounts of racially motivated eugenics, psychiatrists of that time were largely drawn to this movement for professional rather than ideological reasons. He urges readers to consider the historical environment in which these psychiatrists worked and lived, and to not condemn them for paths not taken [31]. Braslow corroborated this conclusion by studying therapeutic practices of the twentieth century at a California state psychiatric hospital. His research demonstrated that psychiatrists rarely relied on eugenic rationales for decisions to sterilize hospital patients and more often "remade sterilization into a therapeutic procedure aimed at solving what they believed to be their patients' individual needs" [37, 38]. Without excusing this behavior, he acknowledges the existence of competing rationales for the perpetuation of such practices. Psychiatrists were largely motivated by relieving the suffering of their patients. Second, they were preoccupied with public policy and the need to legitimize their profession at a time of asylum medicine for patients with chronic and intractable diseases.

By examining the history of a professional community and its adoption of a discourse and practice, one sees how a biomedical theory can translate into a narrow and detrimental policy. It is important to acknowledge these missteps in history to ensure that future policies consider a holistic approach, which includes careful examination of racial identity, culture, and diversity.

Medical Experimentation on Persons of Color

During the time of slavery, African Americans were often sold to physicians and used as experimental subjects. The basic premise that perpetuated systemic racist experiments was that African Americans were inferior to whites [39]. The heat stroke experiment performed by Dr. Thomas Hamilton [10] and the vesiculovaginal fistula repair experiments conducted by Dr. J. Marion Sims [40] are among the many examples of how slaves were exploited to study medical conditions. Among the most atrocious and renowned medical experiments perpetrated against the black community was the Tuskegee syphilis experiment conducted by the US Public Health Service. This 40-year experiment studied the natural progression of syphilis in 400 African-American males, under the premise of treating them for "bad blood" [41]. Participants were deceived into participation and offered no opportunity for informed consent. They were manipulated into continuing their participation with the promise of free annual physicals and coverage of their burial expenses. Most remarkable were the extraordinary lengths to which researchers went to withhold treatment. Despite evidence to the contrary, the Tuskegee experiment was deemed necessary, since notions of racial differences in the sexuality of blacks and their susceptibility to sexually transmitted infections were widely accepted in the medical community. Representatives from the Centers for Disease Control on two separate occasions in the 1960s determined that it was necessary for the study to continue. The prevailing idea was that medical care could not alter the evolutionary

projection for blacks [41]. It took a public outcry, sparked by an article written in the *New York Times*, to bring about the Tuskegee experiment's end [42].

Experiments such as Tuskegee have perpetuated mistrust among black Americans and deterred them from participating in medical research. During the 1980s and 1990s, research aimed at understanding blacks' underrepresentation in clinical research found that their exclusion was due to mistrust, as well as the pervading thought that white males were more generalizable to the population [36]. Later studies of minority participation found that mistrust was an underlying theme even when participants were unaware of the Tuskegee experiments [43].

The effect of underrepresentation of African Americans in medical research has had a profound impact on racial health disparities. Their involvement in research is crucial for understanding disease prevalence and effective treatment. Drug metabolism serves as one example. Ethnic variations in the metabolism of drugs are not uncommon. Without sufficient data, accurate dosing in subgroups cannot be determined [39]. Efforts to eliminate racial disparities in research remain largely ineffective. Research designed to eliminate racial disparities often focuses solely on mistrust and fails to acknowledge other linkages to racism [44].

Racial Oppression in Medical Education and Organized Medicine

The Flexner Report and Its Impact on African-American Health

In 1908, the American Medical Association Council on Medical Education and the Carnegie Foundation for the Advancement of Teaching collaborated to improve health care. The foundation invited Abraham Flexner, a professional educator (and nonphysician), to survey the quality of medical schools. Flexner's approach included an ideal in line with the German model of medical education—one that had been in place at Johns Hopkins—which primarily focused on scientific and laboratory medicine. Some observed that it overlooked patient-centered ideals, the role of health and healing, and a consideration of social issues, particularly those affecting vulnerable populations [45–48]. After the Civil War, southern medical schools refused admission to black students. In response, missionary groups established medical schools, as did black physicians, who developed independent schools.

In the late nineteenth century, as many as 12 black medical schools existed. There were nine black medical colleges at the time of Flexner's survey and only seven when he wrote his report in 1910; they included Flint in New Orleans, Leonard in Raleigh, and the Knoxville, Memphis, and Louisville schools. Given the lack of resources and standards, they were under scrutiny for reform [49] (Table 1.1).

When Flexner's report was released in 1910, he recommended closure of all but two of the seven black medical colleges (Howard University Medical Department and Meharry Medical Department of Central Tennessee College). He offered no mechanism for population-based needs assessment to develop a workforce to serve the nearly 10 million black Americans living at that time (despite his knowledge of