ABSTRACT

Between the Civil War and the turn of the twentieth century the American medical profession expanded greatly both in size and in attention paid to scientific knowledge. During this time African Americans, women, and even African American women gained access to medical education through the proliferation of new medical schools. But this period of unprecedented access was in the end short-lived. The Flexner Report of 1910 was the culmination of years of effort on the part of the medical establishment to restrict entrance to the profession. Like much of the contemporary Progressive reform of the time, the Flexner Report found efficiency and standardization to be paramount and in the process left many of the best parts of professional expansion behind—the diversification of medical students and doctors in terms of sex and race. While most schools were technically coeducational by its publication, within a few years of Flexner, two of the three women’s schools were closed and all but two of the seven African American schools were shuttered. The Flexner Report marked the beginnings of a concerted effort to raise the standards of medical education in the United States and Canada but had far-reaching consequences for women and African Americans students and physicians as well as implications for the care of their future patients.
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INTRODUCTION

By 1910, American medicine was reacting to a half century of substantial growth and change. The period between the outbreak of The Civil War and the turn of the century had seen surgery and nursing develop from skilled trades into organized professions. Increasingly the place of care moved out of the domestic sphere and into newly established city hospitals and asylums. The growth of bacteriology and germ theory had a significant impact on everything from immigration processing practices to the treatment of disease. Rapid population growth, especially in cities, and a focus on public health brought the interests of government and physicians into alignment. Improvements in transportation gave patients more choices for treatment than their local physicians and gave physicians a more capitalized market to compete in. Hospitals were no longer strictly for the destitute or people without family to nurse them at home, they were becoming in equal parts clinical laboratory and place for the care of those with acute illness. The reorganization and response of the medical establishment to this change is epitomized in the publication and thorough internalization of Abraham Flexner’s “Report on Medical Education in the United States and Canada” in the summer of 1910. The Report simultaneously solidified and narrowed the scope of the professional position of two special groups of American physicians, African Americans and women. These groups emerged within the medical profession in the late nineteenth century during a period of increased access to higher education through a combination of private lobbying, public activism, and persistence.
In comparison to the medical practices and technology of Western Europe the United States clearly lagged behind. The French led the way in integration of clinic and hospital study for students, the German model of combined laboratory practice and education was the envy of many other schools and produced much of the groundbreaking work in bacteriology like that of Henle and Koch, and beginning in 1858, Great Britain regulated professional licensing through the General Medical Council.¹ By comparison American medicine was highly variable in quality precisely because it was not lacking in quantity. The proliferation of medical schools of a variety of medical sects—homeopathy, hydropathy, Thomsonianism and other forms of medical botany—from the 1850s through the turn of the century was significant. By the time Abraham Flexner published his report in 1910 he counted 150 schools of varying “sects” in operation, down from 166 in 1904.²

Complicating this period is the incredible historical moment that scientific racism was having in American public opinion, government policy, and laboratory science. Fueled by the legacy of the scientific revolution, thinkers like Francis Galton, and the social politics generated by the debate around Charles Darwin’s On the Origin of the Species, phrenology and racial hygiene, were used to explain and perpetuate racist attitudes that have had a lasting impact on the medical profession.³ Within a wider society epitomized by racial segregation, if African Americans were going to get quality

² Abraham Flexner, Medical Education in the United States and Canada (New York: Carnegie Foundation for the Advancement of Teaching), p 115.
medical care they were going to have to provide it to themselves. As medicine became increasingly institutionalized and removed from local practice, it became more formally segregated. Black patients and families, especially in the south, who were funneled away from their local physicians white or otherwise, and lost the ability to negotiate and have some autonomy over their own care. They also reported having to wait until all other non-black patients had been seen before they were allowed to be treated and being turned away if there was not enough room in the segregated ward. The African American medical establishment’s response to increasing segregation was to create their own institutions: African American hospitals, medical schools, nurse training programs—an entirely separate system that could provide care for and by African Americans.

This paper will examine the conceptions of the place of African American physicians through the eyes of the medical establishment and through their own writing using Abraham Flexner’s Report and the Journal of the National Medical Association, respectively. It will also compare the status of white and African American women physicians to better contextualize the status of African American health professionals. By comparing white medical establishment ideas about African Americans with African American doctors’ own construction of professional identity we can see differences in what health care issues were seen as most important and each group’s imagining of the future of African American medical education and practice.

The fate of African Americans and women within American professional medicine was heavily shaped by the Flexner Report. Flexner set out to scientifically

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evaluate the educational and social value of Canadian and American medical schools. In the process he suggested specific professional, educational, and political reforms, designated what made a student fit to study medicine, and calculated how many physicians the country would need based on each region’s population density and the skill level of the physician which Flexner argued was directly proportional to the status of the medical practitioner’s alma mater.

THE REPORT

The Carnegie Foundation for the Advancement of Teaching was only five years old when they published Abraham Flexner’s “Medical Education in the United States and Canada” in 1910. At the time, Abraham Flexner was most well-known for his successful prep school in Louisville, Kentucky that used free thinking teaching methods with “no formal curriculum, no regular grades, no student achievement records. It was essentially a large-scale experiment in individual tutoring.” Was someone who refused traditional educational methods and had no formal medical education himself really the man to evaluate the way professional medicine was being taught? Multiple authors have suggested that Flexner was selected not just for his erudite writing style but his tendency to reinforce the reformist ideas of Carnegie Foundation President Henry Pritchett. But it would be a mistake to credit the reform of medical education and widespread implementation of scientific medicine entirely to the Flexner Report. The American Medical Association’s Council on Medical Education (CME) had “evaluated the nation’s

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medical schools three times, twice using state medical licensing board results and once through personal visits.”

Editorials in the *Journal of the American Medical Association* and correspondence from AMA leadership made appeals to both state licensing boards and the schools themselves to increase entrance standards and update curriculum. The medical establishment in its various forms had been trying to reign in proprietary and poorly performing schools for years before they turned to the Carnegie Foundation.

Using an outside organization was in this case a strategic choice: it allowed the AMA a more thorough inspection of schools and the ability to get its message of reform across without resorting to infighting among its own members at a time when it was focused on advancing the place of scientific medicine economically and in the public sphere.

Flexner repeatedly used the rhetoric of science, disease, and sickness to communicate his perception and evaluations of the state of medical education to his audience. “Medical colleges have multiplied without restraint, now by fission, now by sheer spontaneous generation,” he argued, virtually using the definition of cancer to describe the growth of new schools. Instead of economic growth, Flexner writes about schools in somewhat grotesque terms of overpopulation: “The United States and Canada have in little more than a century produced four hundred and fifty-seven medical schools, many, of course, short-lived, and perhaps fifty still-born.” A footnote clarifies that by “still-born” Flexner was discussing fraudulent schools. As a rhetorical device the use of

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10 Ibid, 6.
scientific language is successful in accentuating a point and is an obvious effort to establish Flexner’s own medical knowledge. But taken with his habit of consistently misapplying the word “allopathy” (understood at the time to be interchangeable with “scientific medicine”) it also seems to aim the Report at a less medically literate audience like outside reformers and interested financiers beyond or on the fringes of the medical establishment.

At other times Flexner uses industrial and economic rhetoric: “Over-production is stamped on the face of these facts…over-production of cheaply made doctors cannot force distribution beyond a well marked point. According to Gresham’s law, which, as has been shrewdly remarked, is as valid in education as in finance, the inferior medium tends to displace the superior.” The economic fears of physicians at this time were substantial. Graduation from a medical school, even a highly regarded one did not secure a profitable career. This helps to explain the proliferation of new schools in the 1870s and 80s: if the practice of medicine was not proving fiscally tenable, physicians could always team up and open a medical school to boost their income, collecting student fees for faculty salaries. Flexner argued that the “commercial treatment of medical education is intimately connected [to] low standards and give[s] the medical schools access to a large clientele open to successful exploitation by commercial methods.” To some degree, this argument lends itself to competition between the schools for student fees. Schools with a secure endowment from university budgets, charities, or states, can hold higher standards
because student fees are not an operational necessity. Secure funding allows schools not only to teach scientific medicine but practice scientific management.

Throughout his cross-continental school inspections between 1908 and 1909, Flexner makes note of the patient in the abstract or in the collective, but never as an individual. Increasing the number of well-trained doctors improves the general social body he argues, and particularly that of the collective white social body, but he neglects to share how scientifically trained and clinically proficient physicians will be better prepared to save lives and heal the sick. They understand and advance the “overwhelming importance of preventative medicine, sanitation, and public health” but he fails to connect that to the individual or even the reader. This is an easy argument to make in relation to Flexner’s systemic use of scientific methodology in his report but never one he bothered with. Privacy concerns as they exist today would not have stopped Flexner from providing case reports from individual schools, or associated dispensaries and hospitals nor would it have stopped him from speaking in generalities about disease and public health in areas with more proficient doctors and better schools. The Flexner Report is about many things institutionally speaking but it is not about patients or what they stand to gain from educational reform. It is about what the profession stands to gain. This could be in part because “modern hygiene, largely the outcome of bacteriology, has elevated the physician from a mainly personal to a mainly social status,” leaving the patient to be treated not individually but as part of a larger group. Flexner also claims that the poor

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11 Ibid., 6, 14-18.
12 Ibid., 67
13 Ibid., 68
rural patient need not worry because doctors trained in the new system will not just conglomerate to cities as they often did anyway where their earning potential is higher and their clinical opportunities more frequent. The very poorest deserve the very best doctors and “there is no magnet like reputation; distance is an obstacle readily overcome by those who seek health. The poor as well as the rich find their way to shrines and healing springs.”\textsuperscript{14} If he had been privy to more clinical exposure himself he would have known that the poorest sick at the time could rarely afford a doctor let alone travel great distances ill, to a city to procure care.\textsuperscript{15} Many physicians, regardless of race or gender shared this view with Flexner. They set aside realities of patients’ personal economy and class for a more teleological view of “scientific progress.”

As patients had more options to choose from when they became ill, medical students had a large variety of schools to choose to attend. As far as sectarian physicians went Flexner made little distinction in evaluation between the schools based on “sect” and few generalizations until Chapter X: “The Medical Sects” and he does this discreetly. “No allusion has been made to medical sectarianism. We have considered the making of doctors and the increase of knowledge; allopathy, homeopathy, osteopathy, have cut no figure in the discussion.” Flexner claims that sectarianism is fine so long that it is based in science and not dogma, “modern medicine has therefore as little sympathy for allopathy as for homeopathy.” But a few paragraphs later he states that “only three or four are entitled to serious notice in an educational discussion; The chiropractics, the mechano-therapists, and several others are not medical sectarians, though exceedingly

\textsuperscript{14} Ibid, 144.
\textsuperscript{15} Ibid 67, 144.
desirous of masquerading as such; they are unconscionable quacks, whose printed advertisements are tissues of exaggeration, pretense, and misrepresentation of the most unqualifiedly mercenary character. The public prosecutor and the grand jury are the proper agencies for dealing with them.” The “homeopathists, the eclectics, the physiomedicals, and the osteopathic schools” are all fine with Flexner so long as they too up admission standards and provide scientific and clinical education to their students, subscribing to the scientific methods of “modern medicine.”

Flexner spends the ten pages of Chapter X discussing at length the dangers of commercial sectarianism. By contrast, he spends the two pages of Chapter XI and two of Chapter XII discussing place of women and African Americans in his reconstructed medical system. Lack of length was not due to an inability to find enough to discuss about their roles, the pages are rich with commentary, it’s that African Americans and women were no threat to the new system of education he was proposing.

When it came to money, Flexner gained incredible access to receipts and account books to understand the annual income of each school. “Of our 155 medical schools, 120-odd depend on fees alone. There are in the United States and Canada 56 schools whose total annual available resources are below $10,000 each,—so small a sum that the endeavor to do anything substantial with it is of course absurdly futile. There is not a shred of justification for their continuance.” He then goes on to name them and list their budgets “California Eclectic (Los Angeles) estimated income $1060; Pule Medical College (Cincinnati) estimated income $1325…” To have been able to publicly name and

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16 Ibid, 156-8.
shame these schools and their students was something only enjoyed by someone outside the profession entirely and something the CME did not do in previous school reviews.17

Understanding that the profiteering schools were already on their way out and state licensing exams were about to get tougher, Flexner notes that “it has in fact, become virtually impossible for a medical school to comply even in a perfunctory manner with statutory, not to say scientific, requirements and show a profit. Nothing has perhaps done more to complete the discredit of commercialism than the fact that it has ceased to pay. It is but a short step from an annual deficit to the conclusion that the whole thing is wrong anyway.”18 Here Flexner is drawing financial stability as a marker of a high quality school.

Many schools, but black and women’s schools in particular, were drawing financial support from donations and were already heavily subsidizing student fees.19 In his report Flexner writes of Leonard Medical School in Tennessee as “clean and exceedingly well kept” but earning under $5000 per year. After the turn of the century donations to black schools may have been harder to come by: “the younger generations are not imbued with the ideas and enthusiasm of the old anti-slavery agitators, workers and friends,” wrote Charles F. Meserve, the second president of North Carolina’s Shaw University. 20 At one point, Leonard students literally built their school by laying brick

17 Ibid, 137.
18 Ibid, 11.
for the plant. If school closures are drawn up to lack of funds and therefore an inability to provide a high-quality education to students, why was Flexner’s advice not to increase funding for these schools that so clearly had a purpose and fulfilled his own designs on the future structure of medical education? The unendowed medical schools, the umbrella under which the private schools serving women and African Americans fell, were those bearing the largest financial risk. The Flexner Report’s power lay not in its assessment of instruction or facilities but whether it deemed a school worthy enough of private charitable investment as the cost of educating medical students rose drastically with the necessity of laboratories, good faculty, longer courses of study, and maintenance of clinical facilities.

Flexner is forthright in explaining that five of the seven black medical schools be closed, claiming that only Howard in Washington, DC and Meharry in Nashville are “worth developing”.

21 In this, Flexner literally means worth investing money in—the criteria being have they been financially solvent up until now. “The subventions of religious and philanthropic societies and of individuals can be made effective only if concentrated. They must become immensely greater before they can be safely dispersed.”

22 Government funding for higher education—particularly for institutions not affiliated with a strong state university as was the case of most African American schools—was minimal. The major sources of revenue for schools like Leonard and Flint and all of the women’s schools were student fees, alumni donations, and endowments from the Carnegie and newly formed Rockefeller philanthropic organizations.

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21 Ibid., 181.
22 Ibid., 181.
In her study of the failed Leonard Medical School at Shaw University, Darlene Hine contends that, “actually, the medical schools established for blacks, with the exception of Meharry and Howard, were an endangered species long before Flexner’s evaluation appeared. As early as the 1890s the Association of American Medical Colleges (AAMC) and various state licensing boards of examiners had already adopted significant reforms including higher admission standards, a more rigorous curriculum, and tougher requirements for graduation. Thus, the winds of reform within the medical profession were already evolving into gusty gales spelling doom for the ill-equipped and financially unstable institutions, both black and white, long before the publication of the Flexner Report.”

The Report was thus more of a herald of change to come rather than a nail in the coffin.

Flexner has a two-fold argument to make when it comes to money. First, the market will take care of inadequate schools if, second, the appropriate regulations in regards to curriculum, facilities, state boards, and prerequisite studies are made and enforced. This will in theory shrink the number of schools that can afford to provide laboratories, partner with hospitals and dispensaries to give students clinical hours where they are not only welcome, but engaged in treatment (and don’t have to pay the school for the privilege of entering the clinic as many students did). This was supposed to cut the student pool—and thus the available fee-gathering pool—down to only those who have two years of college completed. Flexner calculates that the country can be supplied with sufficient numbers of better trained physicians with only 31 schools. Hedging off the

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protestations of schools he called onto the carpet Flexner says that, “the strength of the argument advanced in this chapter is not dependent on the absolute accuracy of the figures cited. Actual income may vary from our estimates a few thousand dollars up or down; we may have failed to consider this offset or that. It has been, as a matter of fact, utterly impossible to get figures that represent exactly the same items in all, or even in many, institutions. An improvement in institutional book-keeping would have to be effected in order to make accurate comparison possible. None the less, the picture is on the whole fair and reliable.”24 In the same breath he shifts any inaccurate accounting back onto the schools and complains about them not freely opening up their books to a would-be inspector.

It is unclear in the early chapters of his report whether Flexner will position himself on the side of “nature’s own effort at readjustment,” in a free-market resolution to the problem of too many schools or he will argue for an interventionist state solution. It isn’t until Chapter IX where he makes the case for the state and says definitively that, “the right of the state to deal with the entire subject in its own interest can assuredly not be gainsaid. The physician is a social instrument. Disease has consequences that immediately go beyond the individual specifically affected.” It is not until Part II that he evaluates each school’s business organization (a joint stock school versus a university-affiliated school or an independent school), entrance requirements, attendance, teaching staff, budgets, laboratory facilities, clinical opportunities and dispensary before generalizing about the educational needs versus realities of each American state based on

24 Flexner, “Medical Education,” 141.
what role they have to play in the proper education and distribution of physicians among their population. Only then does it become clear that Flexner believes the market and the greed of the independent schools’ proprietors are to blame for the overabundance of poorly trained doctors and therefore they should not be trusted to fix medical education without state oversight.25

Flexner commented not on the state of medical education alone but on the practice and organization of the early twentieth century profession. Flexner’s treatment of women and African Americans is exact and quick, covering four pages total between the two groups in separate chapters. The brevity of these chapters is remarkably inconsistent with Flexner’s detailed, and at times verbose writing in the previous 160 pages and makes the ten pages on “The Medical Sects” seem like a dissertation. However, his pronouncements on the training and roles of African Americans and women would have a lasting impact. This paper will track what happened to African Americans and women who began receiving formal medical education as a result of the school boom in the last half of the nineteenth century in the aftermath of the Flexner Report. It argues that the Report canonized the legitimacy of female and African American practice but did so in a way that did not support the growth or expansion of their place beyond the bounds of a domestically and racially segregated American society.

The Flexner Report is a progressively-minded reform text and seeks to centralize and standardize medical authority. Flexner, with the AMA and Carnegie Foundation behind him, reestablishes what is considered “modern medicine” as wholly based in

modern science. Just as the age of “democratic medicine” was coming to an end, an equally less democratic approach to education would emerge. Though Flexner and other Progressive educational thinkers like John Dewey pushed for social advancement, their flaws in addressing the education of African Americans and women were plentiful. Flexner spent more time diplomatically dealing with the question of medical sectarianism—an economic threat—than gaining a deep understanding of the problems and opportunities offered by reform in the medical education of women and African Americans.

The place of African Americans in medical America at the turn of the century was precarious. Many of their countrymen, Flexner included, considered them a formal public health problem: “he has his rights and due and value as an individual; but he has, besides, the tremendous importance that belongs to a potential source of infection and contagion.” Flexner is promoting a dangerous assumption that African Americans do not simply encounter serious disease more frequently than their white neighbor but that African Americans themselves are the vectors of disease. On this false basis Flexner proposed a slightly different curriculum for African American schools, “schools to which the more promising of the race can be sent to receive a substantial education in which hygiene rather than surgery, for example, is strongly accentuated.” Flexner is not communicating a need to alleviate the disproportionate African American burden of disease, just that such disease should be contained and kept away from whites.

According to Flexner the African American physician and nurse have as much a clinical calling as well as a civilizing one: “if at the same time these men can be imbued with the missionary spirit so that they will look upon the diploma as a commission to
serve their people humbly and devotedly, they may play an important part in the sanitation and civilization of the whole nation.” Black doctors to Flexner are not just important to black people, the only people they will usually be allowed to treat, they are even more important to protecting white people precisely because of his fear of racial contagion. “Ten million of them live in close contact with sixty million whites. Not only does the negro himself suffer from hookworm and tuberculosis; he communicates them to his white neighbors.” Flexner seeks to control the black population and any disease they may expose the white population to by directing the education of black medical students. The argument is based less on upliftment or better health for blacks than it is on racial control of perceived threat to whites. Of the seven black medical schools operational, Flexner recommends only Howard and Meharry to stay open.26 Given the gravity Flexner ascribes to the public health danger African Americans pose to whites, reducing the number of black medical schools seems counterintuitive.

Flexner wanted education for African Americans to be structured differently than that of white students. Flexner’s analysis of “The Medical Education of the Negro” interlinked the progress of all African Americans with the quality of medical care provided to them but he also left the burden of the care on black physicians and perpetuated a Jim Crow standard where black physicians could only treat black patients: “The practice of the negro doctor will be limited to his own race, which in its turn will be cared for better by good negro physicians than by poor white ones.” The idea that white physicians wouldn’t treat black patients was not always true especially within the context

26 Ibid., 180-1.
of local communities. Lynn Marie Pohl examines the broad degree of African American autonomy in patient-physician relationships: “small-town physicians’ continuing reliance on interpersonal practices of medical care, made for an erratic but potentially distinctive cross-racial encounter—one involving a greater degree of negotiated authority.” While the Flexnerian standard was assumed to be segregation, or having a physician nearby of an appropriate race, this was not always the reality.

The Flexner Report communicates high racial anxieties in medicine, explicitly linking race to disease and seemed as concerned with sanitation as with providing quality education. “The negro must be educated not only for his sake, but for ours. He is as far as human eye can see, a permanent factor in the nation.” Here Flexner sounds almost resigned to the “permanent” presence of African Americans and black doctors. “Our” sake implies that Flexner is not anticipating a black readership and considers the medical establishment he is writing for to be white. Flexner, the son of German Jewish immigrants who never mentions the rampant restrictions and prejudice at this time against Jewish physicians like his brother Simon, manages to draw a line of practice based on skin color and associate color with disease.

Approaching segregated medicine from a class context, Todd L. Savitt characterizes the origin of many male physicians of color as usually not of great means. “Their letters of application to medical schools; their correspondence with school authorities about scholarships, summer jobs, and money matters; and the writings of

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contemporary observers about their situations indicate that few come from “monied” backgrounds. Most had limited funds and outstanding debts until several years after opening practices.”29 This contrasts with what we know about the class background of most white women physicians who have left records. They were usually from comfortable, educated families.30 The class backgrounds of white women and African American physicians mattered and made it difficult to gain access to white, mostly male, medical schools and societies, for these were social as well as professional organizations.

In 1870 when the women of the Woman’s Medical College of Pennsylvania (WMC) applied for full and equal membership in the AMA upon graduation, the following was recorded in the minutes of the twenty-first annual meeting of the AMA: “The Committee on Ethics presented a report recommending the admission of the delegates from the Woman’s Hospital and the Woman’s Medical College of Philadelphia.” The AMA tabled the argument until “the majority of the Committee on Ethics be respectfully requested to inform this Association on what principle the delegates of the Medical Department of Howard University were excluded from membership in this Association.” Women couldn’t enter the AMA until African Americans did and vice versa.31 The AMA would continue to deny membership to African Americans until 1964. The question of race would come up continually during that session while the admission of women was not discussed again. African Americans would gain admittance in the 1960s, while the first woman would be admitted in 1876. It

29 Savitt, Race and Medicine, 273.
is important to note that the nature of sex and race discrimination took on a classically Jim Crow-like form. State and local branches of the society were devolved the power from the national organization to admit, or not, members of their own choosing and societies often took race as a precondition. There were no national guidelines or process. Not once in the minutes were “negro women” or “black women” referenced, thus we can then infer that the idea of a black woman physician was not even on the AMA’s radar. The AMA used the membership controversy to pit gender against race, and kept both groups out.

Thus when African American medical professionals found Jim Crow in the membership practices of local and national medical societies, John A. Kenney, a physician at Tuskegee decided that African Americans needed their own professional society.

THE NMA AND ITS JOURNAL

The National Medical Association, a society of black medical professionals was organized in 1895 in response to three decades of exclusion from the AMA. In 1909, as Abraham Flexner was making his rounds inspecting schools, the NMA launched its medical journal. As its prolific Editor from its inception to 1919 Dr. Charles V. Roman would later remember, the Journal began “without friends, without experience and, for the most part with an indifferent clientele.” As a rule, African American medical schools and institutions were perennially cash strapped and the Journal was no

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exception. In the news and comments sections of nearly every issue in the early years of the Journal was always soliciting donations for medical schools and hospitals or chastising NMA members who weren’t subscribing to the Journal. In 1913, CV Roman scolded the “indifference, cupidity, and personal ambition” of the “large per cent of people that are utterly indifferent to the welfare of their profession, their country, and their kind,” when members did not pay their subscription.

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Figure 1, footnote 36 The editorial staff of the Journal of the National Medical Association, 1914. Charles V Roman, MD seated in chair; John A Kenney, MD left. courtesy of the National Library of Medicine.

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Each issue of the *Journal of the NMA* contained about 50% scientific articles and case reports usually revolving around new or interesting surgeries, 30% editorial, and 20% intrasociety communication and news. “Sketches from Life” a recurring feature put together by *Journal* staff included short stories, some poetry, and comedic narratives (frequently at the expense of Irish and Jewish immigrants).3536

The NMA was organized at Booker T. Washington’s Tuskegee Normal and Industrial Institute a highly influential trade school for African Americans in Alabama. At this time, Washington himself was the most important political and social voice for African American community and was frequently deferred to on matters of funding, government policy, and education. The *Journal* was published in Tennessee where the editor in chief Charles V Roman was in ear, nose, throat, and eye specialty practice. The elite black rhetoric of the “talented tenth” was not uncommon. Neither were Christian overtones found in parables, biblical quotes, articles, and speeches. Frustrations with other members of their own race also abounded but were usually directed at root causes such as poverty and lack of education. They also included commentary on social Darwinist theory: “The pages of history are written largely with lessons of how nation after nation has fallen through physical degeneration and all evils consequent upon the ignoring of laws of health. The only difference between these people of early times and ourselves, is that they knew not these laws.”37 This rhetoric suggests that the *Journal*

36 “NMA Editorial Staff” from the National Library of Medicine Images from the History of Medicine (1914).
accepted popular scientific theories of degeneration and was wrestling with how to interpret them within the Journal’s own racial context.

Common healthcare issues that the Journal revisited in the period from 1909 to 1919 include hookworm, pregnancy and childbirth, the diagnosis and treatment of tuberculosis, as well as pellagra, a vitamin deficiency that causes skin lesions, delirium, and diarrhea, which was common in rural farmers and difficult to treat at the time. The concerns of the NMA as expressed by its journal overlap with Flexner’s anxieties over hookworm and tuberculosis, which he believes African Americans will “communicate to his white neighbors” but also readily acknowledges poverty as the root cause of hygiene and sanitary issues. The white fear that African Americans were vectors of disease was addressed directly by the Journal. Speaking to his state society of Tennessee physicians in 1911, President HM Green said, “Ignorance and prejudice are trying to fasten upon the Negro race the whole responsibility for the existence of the white plague [tuberculosis] in the United States. It is the common opinion in many sections that the Negro is a walking incubator of tubercular bacilli and that to come into proximity with him is to expose one’s self to a deadly contagion.” 38 African American doctors like Green understood the science of disease transmission and had to remind white counterparts that it was bacteria not blackness that caused TB.

Interestingly, the Journal did not always limit itself to its own discipline and commented on scholarship published outside of medical journals. Speaking to the Southern Sociological Congress in May 1914 titled “Racial Interdependence in

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Maintaining Public Health” CV Roman said, “All of the population healthy and free is a much safer condition than part of the population diseased and isolated. There is a solidarity of interest that can be neither evaded nor abrogated. Prejudice may render her Dred Scott decisions—but Fate repe... segregated medicine, he goes on to say, “I am as anxious to emancipate the white man from the hookworm as I am to free the Negro from tuberculosis.”39 Hookworm and tuberculosis alike were both thought endemic within African American populations in the south but Roman is reminding his audience that they were found in white populations too.

Rarely did the Journal comment on the issue of the color line unless it directly affected the practice of African American physicians. The Journal doesn’t bother to engage in run-of-the-mill racism or politics. It does however beat back with a force of racism directed at the profession and raises a skeptical flag in the face of scientific theories that reinforce white supremacy. During the 1918 influenza epidemic the Journal reinterpreted the results of a study of incidence in a WWI American training camp.

“From the figures above quoted the conclusion is inevitable that, living in the same environments and under the same rigid military system, the Negro soldier exhibited a less degree of susceptibility to influenza, which was pandemic, than his white comrade. If, in reports from other camps, made under similar conditions and by trained army surgeons as Dr. Opie and his associates, the same difference in susceptibility should obtain, that circumstance, taken in connection with similar observations in civilian life, ought to

establish the truth of the limited susceptibility of the Negro to the virus of influenza. And, why not?" In the spring of 1914 the Journal staff used the new rhetoric of medical professionalism and collegiality to call out by name a prominent physician and hookworm specialist, Dr. Wardell Stiles, James K. Vardaman, a US Senator, and South Carolina Governor Coleman Blease in a response to racist correspondence printed in the contemporary journal Medical World. The writer asked what could be done “to keep him [African American physicians] down?” In its editorial the journal staff wrote “In the mad quest for notoriety men willingly become professional pariahs.” Both Medical World and the Journal chose to print misspelled words in the anonymous correspondent’s letter “seams” and “applicants”, “here” instead of “hear.” Articles or editorials in defense of the practice of African American pharmacists, dentists, or nurses to a similar degree could not be found.

Introducing an editorial section in the second issue of 1910 that heavily featured articles with commentary on race relations and disease the Journal staff wrote “Say Negro and the said white Southron, whether statesman, philosopher, political economist, sociologist, or ethnographer, at once loses his intellectual bearings. Passion supersedes judgment, prejudice usurps the throne of reason, and opinion subverts evidence.” Fighting science with science and reason would remain the Journal’s most frequently employed argument against associations made by laypeople, politicians, and scientists between African Americans and diseases like syphilis, hookworm, and tuberculosis. The

Journal diagnoses race prejudice as a disorder: “This manifestation must always be looked into and studied closely by those who wish to become expert diagnosticians of Dementia Americana. Note carefully that it is the exact antithesis of reason and experience. The victim of this disease reasons that as black and white are opposite so ‘The knowledge of syphilis as affecting the Caucasian, however profound, will not give one an insight into the conditions confronting the Negro.’” Christian rhetoric was employed too: “Statements that diverge so widely from the every-day fact that one does not know whether to question the writer’s experience or his knowledge of the Commandments. (Possibly HE has in some manner switched the Decalogue to suit his convenience and has made himself exempt from the NINTH Commandment,”) reminding the writer that bearing false witness is a sin.43 Again, African American physicians employed science to counter unscientific racist arguments but it was not uncommon to also use religious arguments as Roman did here.

*The Journal* would occasionally call on its readers to provide medical evidence to prove racist science wrong particularly in studies of hookworm, pellagra, and tuberculosis. “Seriously, it does seem that there is a deal of sound and fury and very little fact in this Hookworm Discussion thus far. Can’t the readers of the Journal furnish the facts? I do not believe the evidence thus far adduced will justify the verdict against the Negro.”44 If race is addressed directly in the *Journal* it is usually to refute the many claims like Flexner’s that associate blackness itself with contagion.

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43 Ibid., 104–6.
What the *Journal of the National Medical Association* represented to the segregated profession was best described by its editor in 1913. Speaking in an address to the Association he used a parable about lynching, “Finally, my friends, we are at a critical period. It is our privilege to make history. Some centuries ago, when learning was scarce and crime was abundant, there grew up on the borders of England and Scotland the following custom: If a highwayman were captured, a difficult verse in the Bible was given him to read; and, so rare was learning, if he could read it, he was liberated; if not, he was hanged. This became known as the ‘Neck Verse.’ If he could read it he saved his neck; if not, his neck was broken. The proposition of a successful periodical published by and in the interest of our colored medical profession is our ‘neck verse.’”

According to records kept by the Tuskegee Institute, 52 people, 51 of them black were lynched the same year. The lowest number they had recorded to date. Removing the imagery of lynching from the context of the United States was a safe way to speak publicly about the scourge of lynching as endemic to the south as any disease. Roman proposes that education is one of the best defenses against the violence of white supremacy but also expresses common “talented tenth” elite black frustrations with lower class and less educated African Americans. The *Journal* also expresses this particular form of internal racial frustration when trying to reconcile eugenic theories with their own race.

In its regular editorial section on Medical Education where the *Journal* would occasionally print old state licensing exam questions or commentary on issues, the *Journal* staff wrote “The tendency to eliminate the inefficient and inadequate medical

45 *The Journal—An Address*, 12.
46 *Lynching, Whites and Negroes 1882-1962,* From the Tuskegee University Archives Repository.
colleges is a step toward better things for the medical profession in particular and mankind in general. We have too many doctors. The inevitable result of over-crowding is lessened compensation and lowered ideals. In the struggles for bread altruism has no place. The remedy for all this is higher educational standard, and closer union among the members of the medical profession. What the medical profession needs is more co-operation and less competition. The fight the A.M.A. is making to raise the professional standards deserves the earnest support of the profession everywhere.\textsuperscript{47} When Meharry received a $500,000 endowment in matching grants from the Carnegie Foundation and the General Education Board of New York the \textit{Journal} wrote, “Although our editorial pages for this number are already crowded, we must give space to this article and some comment thereon. The \textit{Journal} congratulates Dr. Hubbard and Meharry on this prospect of an endowment adequate to its work. By all means, friends of the school should see to the raising of the fund in order to secure the two gifts above mentioned. It should not, and must not, be confined to the Meharry graduates. It is not an affair that concerns the Meharry graduates alone. It’s a National racial affair. It concerns our unborn doctors, and our children whom we wish to make doctors. So it concerns all of us. The \textit{Journal} pledges its support in this movement, and the editor heads the list with his check for ten dollars and calls upon all subscribers to do likewise.”\textsuperscript{48} Unlike Flexner, the \textit{Journal} is making an entirely economic argument and not a moral or dutiful one as one may have expected. In an effort to shore up its fledgling socioeconomic position in a contracting profession the NMA chose to support the AMA and the CME. At any given time, a

\textsuperscript{47} “Medical Education,” \textit{Journal} of the National Medical Association 3, (1911): 235.
\textsuperscript{48} “A Half Million Endowment for Meharry” \textit{Journal} of the National Medical Association 11, (1919): 77.
significant number of *Journal* staff were alumni of Meharry or Howard the two institutions Flexner would put his weight behind. This makes sense and put the value of their degrees and education at no threat. “While the white medical colleges are decreasing in number there is a tendency among colored medical men to increase the number of Negro medical colleges. There are three Negro medical colleges—more than enough—that are striving with some probability of success to meet the modern requirements of such institutions,—Howard, Shaw, and Meharry,” reaching nearly the same conclusion as Flexner.

**WOMEN**

In comparison to the other group Flexner singles out to study, the Report had a similar impact on women’s medical education. Many of the first wave women physicians were not only activists by nature of their profession, but were interested in abolition, suffrage, and child welfare. This pattern holds true for African American physicians too who found themselves concerned with economic inequity, racial violence particularly in the south, and the high mortality rate of African Americans who contracted diseases like tuberculosis. Medical women did not organize nationally until the foundation of the Medical Women’s National Association in 1915, later renamed the American Medical Women’s Association in 1937. AMWA published the quarterly *Journal of the American Medical Women’s Association* from 1946 to 2005 with a brief hiatus while the journal staff reorganized from 1969-1972.

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By 1910 it was no longer an oxymoron to be a woman physician. Flexner even referred to it as a “victory.” In comparison to their European contemporaries, particularly in Great Britain and Germany, the women students and physicians of the US were more numerous but their post-graduate clinical training much harder to come by. Where African American physicians were operating in a system of hospitals that held reserved internship spots just for African American graduates, white women were competing for post-graduate training with the much larger field of white male graduates. The first woman to earn a degree from an American medical school was Elizabeth Blackwell who graduated with her MD in 1849 from New York’s Geneva Medical College but lost the job to nurse Dorthea Dix as Superintendent of Army Nurses for the Union during the Civil War.

Johns Hopkins allowed not one but three female students in with its first class in 1893—but not necessarily by choice. Four unmarried, educated daughters of founding university trustees Martha Carey Thomas, Mary Elizabeth Garrett, Elizabeth King and Mary Gwinn, offered Hopkins half a million dollars for their new school if women would be admitted on equal terms as men. The women had the funds by Christmas and the cash-strapped hospital and professors without a school relented. A similar situation occurred at Harvard in the 1880s except school administrators were forced to pass on a $50,000 endowment because of mass threats to quit from faculty. Harvard Medical School held out on coeducation until 1945. At many universities the medical school was

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51 Flexner, “Medical Education,” 170-2.
52 “Women—Or the Female Factor,” (Baltimore: Johns Hopkins University School of Medicine, 2016).

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one of the only schools or departments that allowed women students; coeducation among undergraduates took another 30 years in the cases of Harvard in 1977 and Hopkins in 1970. Thus if pre-medical education requirements were also to be raised, how were women supposed to earn Flexner’s recommended “two-year college basis” when the undergraduate courses of the same schools were not integrated or coeducational? There were thus structural inequalities when it came to women’s qualifications for entrance into professional training.

The first generation of women physicians began, like Flexner, to question the necessity of separate schools. By the time the report was published, the majority of the most recent generation of women physicians had been educated alongside men in coeducational medical schools but were dropping out at higher rates. For instance, of the first three women admitted to Johns Hopkins in the 1890s, only one, Dr. Mary S. Packard completed her studies. The second and third students dropped out, one because she married the anatomy professor and another because she became a Christian Scientist. Physician-educators like Ann Preston and Clara Marshall seemed to understand that women needed a support system they weren’t getting in coed schools.

AFRICAN AMERICAN WOMEN

In combining what Flexner had to say about women and African American doctors, we can imagine how hard it would have been for an African American woman to obtain quality education, stay in her degree program, and then find a hospital—probably segregated, willing to let her complete an internship. In this regard, every black woman physician that graduated and practiced had beaten her statistical odds at least three times.
But African American women had for some time been part of the health care delivery system of the United States. Some records show that African American women healers tended not just to sick slaves but whites in the surrounding areas. Slave owners often collected fees for their slaves’ outsourced medical services. Sharla Fett has argued for the complex relationship enslaved women had with the skilled labor of health work: “Daily sickcare thus represented both skilled labor and an arena of ‘superexploitation’ from enslaved women of the Americas.”\(^5^4\) This legacy may have actually helped African American women circumvent Jim Crow separations in medicine, for even before Emancipation, Rebecca Lee Crumpler earned her MD at the New England Female Medical College.

The Woman’s Medical College of Pennsylvania welcomed African American students with regularity. When W.E.B. Du Bois was putting together his annual conference at Atlanta University in 1906 the topic was “The Negro Physique.” He wrote to Dean Clara Marshall and asked for numbers of students and graduates “of negro descent” and their addresses. Dean Marshall replied with the names, practicing status, and addresses of twelve women, “not all women whose names are given are personally known to me and the number is so small compared with the total number of Alumnae that it is not possible to make intelligent comparisons. Since there is nothing in our catalogue to indicate differences in color, I fear that the accompanying list is not entirely accurate.”\(^5^5\) Even so, Dr. Dubois’s excitement and surprise at the number can be seen on

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\(^5^5\) Clara Marshall, “Clara Marshall to W.E.B. Du Bois,” (Philadelphia: PA, 1906), From the Archives and Special Collections at the Drexel University College of Medicine, item number a178_005.
his copy of his original letter where he or an associate wrote in parentheses “(12!)” by hand.\(^\text{56}\) A 1962 list shows 13 “Negro graduates” between 1867 and 1910 and 21 between 1919 and 1962.\(^\text{57}\) One student, Eliza Grier, an emancipated slave, would return south every other year to pick cotton alternating a year of study with a year of work to pay for her education. After seven years of rotating education and work in the fields, Dr. Grier became the first woman and the first African American to become licensed by the state of Georgia.

Anatomy lab and dissection were rites of passage for medical students everywhere and they frequently marked the occasion with a staged photo. The unknown African American student in the center of this photo—holding the dissection guide

![Figure 2, footnote 58 students at the Woman's Medical College of Pennsylvania performing a dissection circa 1890, courtesy of the Archives and Special Collections at the Drexel University College of Medicine.](image-url)

\(^\text{56}\) W.E.B Du Bois, “W.E.B. Du Bois to Woman’s Medical College of Pennsylvania,” (Atlanta: GA, 1906). From the Archives and Special Collections at the Drexel University College of Medicine, item number a178_004.

\(^\text{57}\) “Negro Graduates, 1867–1962” (Philadelphia: PA, 1962). From the Archives and Special Collections at the Drexel University College of Medicine, item number a178_001.
evokes a common pose that symbolized knowledge and leadership. The student holding the book would usually direct her group during dissection, instructing them which muscle to peel away next or what the name of the structure was they had discovered in the mediastinum. This African American woman thus not only received a medical education but was a leader in her cohort of white women.\textsuperscript{58} Indeed, black women played important roles in professional medicine that were to have a lasting impact. Halle Tanner Dillon a recent widow and mother of one became the first woman, black or white, to be licensed by the state of Alabama. She would go on to serve at the Tuskegee Institute for the majority of her professional career, reshaping the provision of healthcare for African Americans in the Deep South.

Despite the existence of well-trained and skilled African American female physicians, the African American men who ran the journal clearly preferred African American women to be nurses. After 1910, the leadership found that so many nurses were subscribing to the \textit{Journal}, they began a regular column just for them titled “Of Interest to Nurses” that published graduation announcements, rates of pay in different parts of the country, and stories by nurses. Women were directly encouraged and commended when they joined the ranks of educated nurses, who were increasingly in demand as medical procedures became more complicated. Dr. Charles V. Roman, used the position of formally trained nurses to circumscribe the role of women and to chastise

\textsuperscript{58} Woman’s Medical College of Pennsylvania, “Students conducting dissection” from the Archives and Special Collections at Drexel University College of Medicine, Legacy Center (Philadelphia: PA, 1890) Item number p4870.
women studying to be physicians as unsexing themselves by using both Christian
scriptural references and evolutionary science of the time.

Science and common-sense as well as religion recognize the scriptural
declaration, ‘Male and female made He them’. The problem of the sexes is a
fundamental one, and is as old as human reason. A woman is not a man and a man
is not a woman. This differentiation of the sexes is the finest fruit of evolution.
The higher the type the more pronounced the difference in sex. The Joans of Arc
and the Hypatias may be canonized as saints but they will never be recognized as
ideal women. The sexes must develop along parallel and harmonious but
distinctive lines—forever separate as the right hand and the left, yet united to
form a perfect race. This does not refer to those necessary struggles for existence
made by unsupported women. A share in these struggles is the birthright of every
creature. I cannot however join with those who find cause for rejoicing in the fact
that we have 126 women plumbers, 545 carpenters, and 193 blacksmiths in the
United States. Why we have a right hand and a left hand has never been
satisfactorily explained. Whether the preferred use of the right hand began by
chance and was continued by heredity or was born in some primeval necessity
and transmitted of some recondite, morphological law, we are unable to
determine. It is quite evident, however that two hands are necessary and the right
had will continue to be the favorite with the majority—the left hand only
occasionally taking its place. To know one’s work one must first know oneself.
Your first duty then, is to recognize the fact that you are a woman. This is
essential to your doing properly a woman’s work.” Roman then goes on to remind
the graduates that even though they have spent money and time on their
professional education that “The end of the trained nurse is matrimony—that Sea
of Honey mingled with hyssop into which run all the springs.”

Women were actively discouraged by the NMA from becoming doctors, through
commentary on trained nurses: “There was a time when the physician was suspicious of
the nurse, lest she should seek to supplant him. Today that conditioned has changed...The
educated physician has not fear of the nurse “taking his job,” and the trained nurse has no
desire to take it. She knows her place. It is the untrained nurse who would be guilty of
such illusion, deception and perfidy.” In the section “Obiter dicta” or “by the way”

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Journal staff joked: “Does an increasing preponderance of females presage racial decay?” was wedged between comments about the origin of coughs, a reprinted article on black capital holdings in the south, and inspirational quotes.\(^61\) It’s unclear whether the writer is referring to a high female birth rate or simply an increasing visibility of black women in public life or the writer’s immediate medical sphere. Even if written as a joking aside, this belies a belief in a perceived female threat and a sort of scientific inferiority of women to men.

Paradoxically though, African American nurses, while writing articles and essays for the Journal, frequently subscribing and writing letters to Journal staff, and performing work of “the highest adulation” in black and white communities, still did not seem to be offered membership in the NMA at this time.\(^62\) African American nurses nevertheless appear to have had an easier time negotiating the color line than African American physicians. In a Flexner-like report on African American nursing schools published in the Journal in 1918 correspondence from nurses recounting their careers and education was included. Bessie B. Hawse a graduate of less than a year from the Tuskegee Institute program told of nursing a family of ten back from the brink of death “That is the only colored family I have nursed, but have had six or seven at once in white families. I have been from North Carolina one week. While there I nursed the wife of a wealthy farmer. I was sent there by a white physician in Atlanta. The house in which I stayed was one hundred and seventy-five years old. The people were lovely to me. The physician was seventy-five years of age, and had been practicing for forty-five years, and

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I was the first trained nurse he had ever had to work with him. I remained there a few days over three weeks, and they paid my railway fare both ways, gave me one hundred dollars, and a cameo ring that had been in the family for years. They asked me to keep it as a token of appreciation. I do not write this in a way of boasting, but thought you might like to know what I am doing. I am now nursing a wealthy Jew. This is my first case with the Jew doctor. Some days I get two or three calls. I have gotten thirty-five dollars per week for some cases. I am very proud of the fact in such a short time that I have been able to practice with Negro, white, Jewish, and German doctors. I have learned something from each.”

This nurse seems acutely aware that she is crossing virtually every cultural and racial divide in American life and medicine with ease and for good pay. Even as a recent graduate her services are in demand from patients and practitioners. She mentions that her training sets her apart not just from other black nurses but from any nurse at all. Perhaps the greatest market shift didn’t occur in professional medicine but in professional nursing. At a time when surgeries and treatments were becoming so complicated that both doctors and patients needed constant monitoring and support from scientifically competent nurses.

African American women entered the medical profession in other ways too. Some were pharmacists, trained increasingly at universities and earning PhDs rather than a traditional apprenticeship. The pharmaceutical secretaries and editors in this period were both women, Amanda V. Gray, Pham D and JPH Coleman, an activist and business owner Julia P.H. Coleman, PharmD, a graduate of Howard’s pharmacy department. Her

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gender was of such note that the Journal staff made an effort to list her as “Mrs. J.P.H. Coleman, Phar. D” where any other women published writers were addressed not by title but by first and last name only as opposed to the stylized first and middle initials followed by last name and degree. But for these and other women, there remained significant financial barriers to joining the NMA. Dues to the Association in 1911 were two dollars, three if you wanted a quarterly subscription to the Journal. Local societies like the state societies of Illinois, Maryland, North and South Carolina, Des Moines, and North Jersey, were approved as official NMA affiliates after review and a five dollar fee. The process for becoming a member of the National society included membership in a local society with the written endorsement of your state society Vice President, President, and Secretary. Later in the century hospital privileges would be based on membership with the AMA and this would provide a basis for denial of admitting privileges to many African American physicians. It is no surprise then given the barriers to entry that women physicians and pharmacists were not frequently associated with the NMA or its journal if at all. In an unofficial capacity the wives of NMA members were frequently cited as attending constituent organization meetings with their husbands and having the responsibility of planning the national annual meeting social functions.

CONCLUSION

In 1880, there were 82,000 total physicians in the United States, roughly one physician per every 163 Americans. Flexner’s ideal ratio based on a German model, was one physician to every 1,500 persons but conceded that the 31 schools he proposed the US and Canada could get by on graduating about 70 students per year would produce a number closer to 2,000 annually. He also calculated “that the existing system came about without reference to what the country needed or what was best for it may be easily demonstrated. Between 1904 and 1909 the country gained certainly upwards of 5,000,000 in population; during the same period the number of medical students actually decreased from 28,142 to 22,145, i.e., over 20 per cent. The average annual production of doctors from 1900 to 1909 was 5222; but last June the number dropped to 4442. Finally, the total number of medical colleges which reached its maximum 166 in 1904 has in the five years since decreased about 10 per cent. Our problem is to calculate how far tendencies already observable may be carried without harm.” If the 1:1500 ratio were to hold true for about 10 million African Americans, there would have to be over 6,000 African American doctors to meet the needs of the population. This was a tall order for just Howard and Meharry to manage on their own and it only stands to reason that Flexner calculated this ratio without regard for how it would function in his segregated system.

CONCLUSION

Of those 82,000 people who listed themselves as physicians in the 1880 census 0.36% (300) were non-white women compared to 2.7% (2300) white women and 0.73% (600) non-white men. This dearth of women of color in the profession thus made the very

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68 Flexner, “Medical Education,” 151.
69 Ibid., 146.
act of pursuing a medical career for an African-American woman an act of resistance to professional norms. By 1920 the numbers of women of color shrunk while numbers of white women and African American men grew in the same period:. 0.14% of physicians were non-white women while 3.8% were white women and 2.2% were non-white men. Between the publication of the Report and 1920 schools like Flint and West Tennessee would close one by one. By 1920 Howard and Meharry would be the only two left. How would 140 new physicians a year, suffice to serve a population of 9.8 million African Americans given that he envisioned a future where medical practice was segregated with black doctors exclusively treating black patients?

Furthermore, white male and female physicians as well as male non-white physicians saw consistent growth in numbers in the 40 years examined even as there were fewer and fewer medical schools after the publication of the Report in 1910. These numbers suggest two things: first, that medical schools expanded the number of seats available in each graduating class and second, black women found substantially fewer of those seats into the early twentieth century.\textsuperscript{70}

So, what is the lesson of the Flexner Report? The CME, AMA, and the established scientific schools got what they had been striving for. Through the restriction of entry into institutions of medical education both through formal and informal methods and the tightening of limited funds paired with the rising cost of scientific medical education, Flexner effectively closed the recently expanded profession back down. When

it comes to African Americans and women, Flexner demonstrates not only a huge missed opportunity but an example of what happens when the investment risk of schools like Leonard and the Woman’s Medical College of Pennsylvania are deemed too high compared to ones with federal money or a strong university affiliation like Howard or Hopkins respectively. In his calculations of physician to population ratios, Flexner didn’t make any special considerations for a segregated system.

The story of the Flexner Report is largely a story about money and institutional support. Where black men had the support of African American institutions, the NMA, hospital internships, and white women had the support of early feminists and financial patronage from wealthy white women, African American women often had neither and found less of it after 1910. The Flexner Report was central not just to educational reform, but to systemic changes that privileged the professional status of white medical men and, by virtue of the racial segregation the Report reinforced, their white patients.
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