United Physicians Alliance
A Physicians Initiative... Finding a Better Way

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"Racism in the American Medical Profession"

A Press Release- January 2024

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INTRODUCTION

Welcome to the United Physicians' Alliance, Inc.! Established in 2016 to address a myriad of concerns from independent physicians, our organization has evolved into a dynamic civil rights and labor organization that fills several voids in the healthcare industry, namely, the denial of equal opportunity, due process, and fair treatment to African American physicians and other healthcare professionals. Our mandate comes directly from the Thirteenth Amendment, U. S. Constitution, as well as several other related state and federal constitutional provisions and statutory laws.

I. MISSION STATEMENT

The United Physicians' Alliance, Inc. is an independent practice association (IPA) with a singular mission and objective of rooting out racial discrimination against African American physicians and other healthcare professionals within the American Medical Profession.

II. VISION STATEMENT

The United Physicians' Alliance, Inc. seeks to enforce the letter and the spirit of the 13th and 14th Amendments, U. S. Constitution, within the Medical Profession, so that all physicians and healthcare professionals can

enjoy the benefits of their chosen careers and professions free of racial discrimination, racial harassment, and other forms of labor reprisals.

III. INDEPENDENT PRACTICE ASSOCIATION

Organized under the auspices of the National Labor Relations Act and similar state and federal laws, the United Physicians' Alliance, Inc. is an independent practice association (IPA) with a singular mission and objective of rooting out racial discrimination against African American physicians and other healthcare professionals within the American Medical Profession.[1]

> [P]hysicians of color practicing in the U.S. frequently experience overt and subtle workplace discrimination from leadership, colleagues, and patients. Experiencing discrimination is associated with negative career outcomes and creates an unwelcoming work environment with a culture of silence around experiences of discrimination; pressure to

[1] In "Discrimination Toward Physicians of Color: A Systematic Review," J Natl Med Assoc. 2020 Apr, 112(2): 117-140, authors Filet, Alvarez and Carnes found:

> Multiple physicians of color in 9 of the 13 qualitative studies reported on the importance of having both personal and organizational support to buffer the negative impact of discrimination. Physicians of color described the importance of family members and friends outside the institution as important sources of support, and because of concern about discussing workplace discrimination at their own institution they also described the need to seek support from physicians or colleagues elsewhere. In terms of organizational support, Nunez-Smith et al. found that compared to their white colleagues physicians of color were less comfortable reporting discrimination at their institution, less comfortable discussing ethnicity/race at work, and did not feel that issues of discrimination were discussed at work; and Peterson et al. found that faculty who experienced ethnic/racial discrimination were less likely to "feel welcomed" at their institution. In interviews with "minority faculty" that included African Americans, Asians/Pacific Islanders, and Hispanics/Latinos at University of California San Francisco, there was a feeling that increasing diversity was not an institutional priority. In interview studies exploring the experiences of physicians of African descent, some participants shared the need to leave an institution due to lack of organizational support41 related to ethnicity and race and the negative affect this lack of support had on workplace climate. According to one URM faculty member in an interview study by Pololi et al., the culture of academic medicine with its focus on the individual can contribute to the perception of a negative and unsupportive workplace climate for Latino and American Indian faculty who may come from cultures centered around family and community. In a study of faculty at Johns Hopkins University School of Medicine conducted by Price et al., participants shared how ethnic/racial bias contributes to a negative "diversity climate" in a number of ways. Four studies identified mentors as sources of support, with 7 studies finding that physicians of color sometimes find social support from selected colleagues and other physicians of color in their workplace, but often needed to find such support outside their institution.

take on diversity-related tasks; and feelings of isolation, fatigue, hurt, and invisibility.[2]

To date, one of the major challenges preventing racial discrimination against Black physicians (and other physicians of color) are peer review processes and procedures.[3]

To that end, the UPA is unique and may be distinguished from other healthcare IPAs whose mission includes making contracts with independent care delivery organizations, and providing services to managed care organizations on a negotiated per capita rate, flat retainer fee, or negotiated fee-for-service basis. The UPA is focused, instead, upon alleviating present-day, as well as the effects of past racial discrimination against African American physicians within the medical profession.

The constitutional and statutory basis for the mission and purpose of the United Physicians' Alliance, Inc. is the 13th and 14th Amendments, United States Constitution and the Civil Rights Acts of 1866, 1871, and 1964.

In 1865, Congress adopted the Thirteenth Amendment to the United States Constitution. This Amendment prohibits slavery, involuntary servitude, as well as the "badges and incidents" of slavery.

Relying upon the *Civil Rights Cases*, 109 U.S. 3 (1883) and *Jones v. Alfred H. Mayher*, 392 U.S. 409 (1968), the United Physicians' Alliance, Inc. stands firmly upon the constitutional position that invidious racial discrimination against African American physicians and healthcare professionals constitutes a "badge and incident" of slavery and should

[2] Ibid.

[3] Sidney Welch and Tricia Hoffler, "An Epidemic of Racism in Peer Review: Killing Access to Black and Brown Physicians," *Journal of Health and Life Sciences Law* (May 2022, Vol. 16: Issue 1)("Recently, the medical profession has experienced a significant increase in the number of adverse medical staff actions against physicians of color. This crisis is one of epidemic proportions and impact, threatening the economic, physical, and mental well-being of African American physicians and taking a corresponding toll on the health and lives of Black patients, who are already negatively impacted by the systemic racism in the health care system.")

therefore be prohibited and punished as both civil torts and criminal violations.

All the other constitutional and statutory provisions, previously cited above—i.e., the 14th Amendment and the Civil Rights Acts of 1866, 1871, and 1964-- were designed, fundamentally, to implement the 13th Amendment, which proscribes divesting African Americans of the natural rights to make and enforce contracts "as is enjoyed by white citizens." See, e.g., 42 U.S.C. § 1981.

To that end, the United Physicians' Alliance, Inc. is an independent medical association (IPA) that is organized around enforcing the 13th Amendment, U.S. Constitution, together with other implementing legislation, in order to abate *invidious racial discrimination* against African American physicians and other healthcare professional within the medical profession.

IV. AFRICAN AMERICAN HEALTHCARE: A HISTORY OF CONSTITUTIONAL CRISIS

The United Physicians' Alliance, Inc. is a civil rights independent practice association (IPA) that is organized around ameliorating the plight of African American physicians and other allied healthcare professionals. Fundamentally, the constitutional foundation of the UPA is the Thirteenth Amendment, U. S. Constitution, enacted by the United States Congress to

abate not only slavery but also all "badges and incidents" of slavery in every facet of American life. As the following historical survey demonstrates, some "badges and incidents" of slavery—which are perpetuated by, e.g., "peer review" committees[4]—are still being perpetuated in the modern health-care industry.

The National Medical Association (NMA) is the largest and oldest organization representing African American physicians and their patients in the United States. As a 501(c)(3) national professional and scientific organization, the NMA represents the interests of over 30,000 African American physicians and their patients, with nearly 112 affiliated societies throughout the nation and U.S. territories. Through its membership, professional growth, community health education, advocacy, research, and collaborations with public and private organizations, the organization is dedicated to enhancing the quality of health among minorities and underprivileged people. Throughout its history, the NMA has primarily focused on health issues related to African Americans and medically underserved populations.

Source: https://en.wikipedia.org/wiki/National_Medical_Association

Akin to the system of the "lily-white" jury system or the "lily-white" political primaries of in Jim Crow-era, the "peer-review" system, within the American medical industry, as it negatively impacts the health, economic security, and career trajectories of African American physicians, perpetuates the past effects of slavery, the "badges and incidents of slavery," and racial discrimination upon African American physicians and the African American community as a whole.[5]

[4] Ibid.

[5] Ibid.

A.

Race Discrimination in Medical Services During the Antebellum and Civil War Period, 1787 – 1840

Wherefore, the United Physicians' Alliance, Inc.'s existence, mission, and vision is connected to the traumatic effects of the transatlantic slave trade and the institution of American slavery upon the American medical services industry, the plight of African American physicians, and the health-care delivery outcomes upon the African American community. As previously mentioned, that connection is both constitutional[6] and statutory.[7]

"African slaves, when coming to the New World, brought with them their various cultural practices and knowledge of medicine." Indeed, the severe illnesses which extreme and traumatic conditions on the slave ships and, later, on the slave plantations, created necessitated the need for quality and adequate medical services among African slaves[8]— the denial of

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[6] The 13th Amendment, U.S. Constitution—abrogates slavery and the incidents of slavery. The 14th Amendment guarantees Equal Protection and Due Process.

[7] The Civil Rights Act of 1866, 1971, and 1964. The National Labor Relations Act.

[8] Christine Andrae, "Slave Medicine," *Medical Practices* (https://www.monticello.org/sites/library/exhibits/lucymarks/medical/slavemedicine.html), citing several sources, including:

> Fett, Sharla M. *Working Cures: Healing, Health, and Power on Southern Plantations*. Chapel Hill and London: University of North Carolina Press, 2002
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> Genovese, Elizabeth Fox, *Within the Plantation Household*
>
> Savitt, Todd L., *Medicine and Slavery*
>
> Stanton, Lucia. *Slavery at Monticello*. Thomas Jefferson Foundation, Monticello Monograph S Series, 1996.
>
> Cotton, Sarah Mitchell: Bodies of Knowledge: The Influence of Slaves on the Antebellum Medical Community at http://scholar.lib.vt.edu/theses/available/etd-65172149731401/unrestricted/CH1.PDF

which placed into jeopardy not only the natural right to "life" of the individual slaves but also the economic investment in slavery itself. Therefore, the provision of medical services to African American slaves was shared by multiple and sometimes diametrically-opposite interests.

'HOW FAR WE HAVE COME'

PHOTO PROVIDED BY BRIAN WASHINGTON

Fifteen African American medical students from Tulane University in New Orleans stand in front of former slave quarters at the Whitney Plantation in Edgard. After Sydney Labat tweeted a photo from the shoot, it went viral, garnering more than 20,000 retweets and 84,000 likes.

Tulane medical students tell story behind viral Whitney Plantation photos

BY MATT SLEDGE
Staff writer

Driving home this summer after touring Whitney Plantation in Edgard, Tulane University medical student Russell Ledet had a conversation with his daughter about the ghastly conditions their ancestors endured under slavery.

Then, at one point, the 8-year-old told her father: "Dad, being a black doctor in America is a big deal. You gotta think about how far we have come."

Those words sparked an idea. And that idea has turned into a social media sensation.

Ledet decided to return to the plantation, on the remote west bank of St. John the Baptist Parish, with 14 other black medical students earlier this month.

They posed for pictures.

In one, they stand tall — wearing white lab coats — in front of a cabin where enslaved people once lived. In another, they are draped around the same porch, still and proud.

All are descended from enslaved people, except for one native of Nigeria.

➤ See TULANE, page 7A

STAFF PHOTO BY DAVID GRUNFELD

Tulane medical students Sydney Labat, left, and Russell Ledet pose Friday in New Orleans. Ledet said his daughter's words first made him conceive of the image of him and his black colleagues standing on the grounds of the Whitney, Louisiana's only plantation dedicated to telling the stories of the enslaved people who toiled there.

Just as the treatment of slaves varied on the basis of the inclinations, whims, and privileges of the individual white slave masters and white slave-holding families, so too did the provision of medical services to the slaves

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Savitt, Todd L. "Slave Health and Medicine": http://www.history.vt.edu/Jones/priv_hist3724/SlaveMed/slaveindex.html

vary, ranging from callous indifference and neglect of the slaves' health concerns to a general interest in preserving the property interest in healthy, productive slave labor.[9]

Regardless, the African slaves themselves early and largely took matters into their own hands and, from the very beginning, they provided self-help remedies—with the West African medicine man, the "root" man, and the spiritual healers appearing early on slave plantations to provide medical treatment and services to the slaves.[10]

"Slave remedies were transmitted orally from generation to generation whereas white domestic healers like Lucy tended to write down cures, along with recipes for preserves and meat pies, in 'receip' books.... Slave remedies tended to be simpler than white medicines. Teas or poultices were made with one or two plants. Scholar Sarah Mitchell Cotton speculates that slaves had less time to gather ingredients and less time to prepare complex mixtures."[11]

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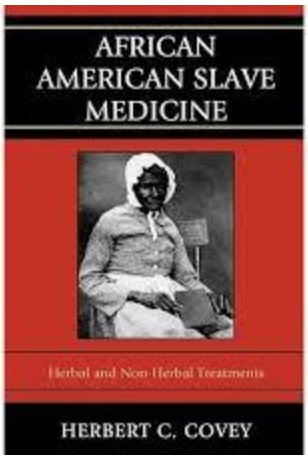
[9] Ibid. ("The health of a planter's work force was critical to economic success. All slave illnesses had to be reported to a farm's overseer or owner, under pain of punishment. The responsibility for the health of slaves often fell to the mistress of the plantation.... Some plantations like George Washington's Mount Vernon which had over 300 slaves had separate quarters for sick slaves. ")

See, also, Colin Fitzgerald, "African American Slave Medicine of the 19th Century," *Undergraduate Review*, 12, 44-50. Available at: http://vc.bridgew.edu/undergrad_rev/vol12/iss1/10 ("The value each slave owner, as well as community, placed on slave-practiced medicine was different from one plantation to the next. This provided a number of different environments where medicine practiced by slaves was both nurtured and suppressed.")

[10] Ibid. ("African healers also felt a sacred connection to plants they found in the woods, and they used elements from African religious rituals when they prepared medicines.... Europeans, however, dismissed African spirituality as 'superstition' and an indication of a child-like mentality.")

See, also, Colin Fitzgerald, "African American Slave Medicine of the 19th Century," *Undergraduate Review*, 12, 44-50. Available at: http://vc.bridgew.edu/undergrad_rev/vol12/iss1/ ("The wide spread uses of medicinal herb and holistic natural plant-based remedies by slaves of the early to mid-nineteenth century were equally as effective in treating ailments of the body when compared to commonly practiced white medicine of the same time era; and, in some cases, medicine practiced by slaves was more effective in treating the physical and psychological conditions of patients than the medicine practiced by their white counterparts.... There were a plethora of different herbs, roots, barks, spices, and other naturally occurring biological components used in slave medicine. Their uses, as well as prevalence, were contingent on their availability and usefulness. Some of these cures worked well, some offered little more than coincidental cures, and others were even a bane to a patient's health. However, each of these of these cures, effective or not, built upon the already pre-established knowledge slaves had of medicine. Their experimentation with various kinds of plant based remedies is what led them to make these great, albeit unknown, breakthroughs in medicine that we still study and use today.")

[11] Ibid., stating:



Although both whites and blacks in rural 17th- and 18th- century America likely shared "home" medical remedies, and shared a deep sense of spiritual connection to the healing process, as well as to the healing arts, the white Christians tended to look upon the black "root" men as practitioners of superstitious witchcraft.[12] This resulted, at least among many slave communities, a bi-furcated cultural system regarding both spiritual and medicinal healing—one that came internally among their own unlettered blacks, and one that came externally from their white overlords.

Thus commenting upon this type of development on a Virginia slave plantation, Professor Andrae writes:

> Lucy may or may not have exchanged remedies with slave "root doctors" and midwives, but as a devout Christian, she certainly would have disapproved of slave "conjurers" who, in the tradition of their forebears in Africa, cast spells and, along with

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Slaves used many of the plants used by the community of their white owners: snakeroot, mayapple, red pepper, boneset, pine needles, comfrey, and red oak bark, to name a few. Slave healers understood the various preparations of pokeweed and how to avoid its dangers while taking advantage of its curative properties. Sassafras root tea was a popular seasonal blood cleanser believed to "search de blood" for what was wrong and go to work on it..... Jimsonweed was used for rheumatism, chestnut leaf tea for asthma, mint and cow manure tea "fur consumption".... Slave midwives would have known and used herbs for "female complaints" and to ease childbirth. Slaves preferred their own doctors to white doctors and their "heroic" purging and bloodletting. For an enlightening look at what it meant to be sick when you didn't own your own body, see historian Todd L. Savitt's on-line essay "Slave Health and Medicine: If You Got Sick And Were Black".

[12] Ibid.

> plants and animal parts, used trickery and intimidation to treat illness of both body and soul. Lucy was a Methodist and the Methodists were known for evangelizing amid slave communities. So it is probable that many of Lucy's slaves, perhaps without altogether abandoning ancestral religious beliefs, adopted their owner's creed. Converted slaves likely would have gained not only her favor but also inspiration from Biblical stories like Exodus that hold the promise of triumph over oppression.[13]

Significantly, from the very beginning, the colonies enacted laws which restricted the administration of medicinal remedies by black or African medicine or "root" men to white patients.[14] Following the slave insurrections of the 1830s, this restriction included even the administration of medicinal remedies by those same "root" men to other black slaves, without express permission from white masters.[15] There was, by this point, a widespread fear that certain "root" men were susceptible to poisoning certain slaves, creating intentional miscarriages, and other self-inflicted atrocities in order to weaken the institutional of slavery.[16]

Hence, from the very beginning of the American colonial period, up to the time of the U. S. Civil War (1861 – 1865) African Americans were discouraged, if not altogether legislatively suppressed, from learning the

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[13] Ibid.

[14] Ibid.

[15] Ibid.

[16] Ibid.

See, also, Colin Fitzgerald, "African American Slave Medicine of the 19th Century," *Undergraduate Review*, 12, 44-50. Available at: http://vc.bridgew.edu/undergrad_rev/vol12/iss1/ ("There was such a rise in the number of African-American herbalists and medical practitioners that the South Carolina General Assembly passed a law in 1749 that prohibited slaves from being employed by physicians to concoct poisons, or administer medicine of any kind. However, slave medicine continued. Many slaves saw medicine as one of their few freedoms left, the freedom to treat their own bodies. Some plantation owners would allow it unless an ailment grew out of hand, while others would only allow it if a physician's aid failed to cure someone.")

healing arts or from practicing medicine—whether non-traditional "West African" medicine or the tradition "Euro-centered" scientific medicine.[17]

Nevertheless, through necessity treating the numerous and perennial bodily ailments of the slaves, the traditional "West African" healing arts went underground: "[i]n fact, the laws were no deterrent. Slave medicine flourished on plantations. While collecting wild herbs and roots, slave doctors, male and female, escaped the boundaries of their working life and perhaps experienced a fleeting taste of physical freedom.

"Certainly, a belief in the sacredness of healing plants allowed them to connect with an authority higher than their owners – be it animistic African deities or a single Christian god. In treating fellow slaves, they became an instrument of divine power. They, not their owner, controlled a patient's body. At its core, slave healing was an empowerment for both healer and patient."[18] This development in the history of African American medicine, then, was closely aligned with the development of the African American underground church.[19]

ii.

The history of the discriminatory, brutal, and inhumane treatment of sick black or African Americans slaves is also rooted in this antebellum period. Perhaps the worst manifestation of this can be found in the 19th-century medical advertisements from medical schools, hospitals, and physicians, which offered to purchase sick or elderly slaves from the planters, in order to conduct dangerous and inhumane medical experiments upon these unfortunate human beings.[20]

For instance, Kathleen Bachynski's article in *The Washington Post*, titled "American medicine was built on the backs of slaves. And it still

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[17] Ibid.

[18] Ibid.

[19] See, generally, W. E. B. Du Bois, "The Souls of Black Folk," *Writings* (New York, N.Y.: The Library of America).

[20] See, generally, William Goodell, *The American Slave Code* (1853) [citation omitted, source found in the public domain].

affects how doctors treat patients today,"[21] not only describes how antebellum medicinal science was developed through the usage of inhumane experimentation upon black slaves and, in the case of gynecology, black slave women, but how that same humane treatment created racist post-bellum perspectives within the American medical profession regarding the medical treatment of black patients.[22]

"We must address the ways racism and slavery shaped American medicine," wrote Bachynski, "not only to right past wrongs but also to confront how that influence continues to affect how patients are treated today."[23]

To demonstrate this truism, one needs to only review the history of the resistance to African Americans who desired to enter in the American medical profession and to practice medicine.

B.

Race Discrimination in the American Medical Profession, 1840 to 1865

The history of the provision of African American medical services during the period 1840 through 1865, which was the year when the U. S. Civil War ended, is largely the history of the "root" man, the midwives, and the self-administered "home" remedies of the plantation slaves. Nevertheless, this history is also marked by several notable achievements among African Americans who sought to before formal, authorized physicians within the American medical profession.

During the years 1846-1847, a "National Medical Association" was proposed in New York City. This organization was founded but was quickly

[21] *The Washington Post* (June 8, 2018). This article excoriates several decisions to memorialize and to honor Dr. J. Marion Sims, the "Father of Gynecology" and past president of the American Medical Association who developed his medical science through the exploitation of black female slaves whom he used for medical experimentation.

[22] Ibid.

[23] Ibid.

renamed the "American Medical Association" in 1847 at a national convention in Philadelphia.[24]

During that same year, in 1847, David Jones Peck, an African American, was awarded the "MD" from Rush Medical School of Chicago, IL. He was the first African American to received that professional and academic distinction.

In 1849, an African American named John Van Surly DeGrasse graduated medical school at Bowdoin College (Maine) and he became the first African American medical officer in the US Army during the U. S. Civil War (1861 – 1865). (In 1864, Rebecca Lee Crumpler became the first African American woman to graduate from an American medical school, the New England Female Medical College in Boston.)

But racial prejudice and the resistance to African Americans entering into the American medical profession were perhaps first manifested at Harvard Medical School. In 1850, that school admitted three distinguished African American scholars: Daniel Laing, Jr.; Martin Delany; and Isaac H. Snowden. Unfortunately, due to protests from their fellow white students, Professor Oliver Wendell Holmes, Sr. expelled all three students in 1851. Not all of the white students agreed with this action and signed petitions in protest of that discriminatory treatment.

Nevertheless, African Americans continued to make progress. For instance, in 1854, the Massachusetts Medical Society admitted its first African American member, John Van Surly DeGrasse, on August 24, 1854. DeGrassed was thus the first African American to be admitted into a U. S. medical society.

During the U. S. Civil War, the Freedmen's Hospital (Washington, DC), one of several federally-funded Freedmen's Hospitals, was established by the Freedmen's Bureau. This was a federally-funded health care facility for African Americans in the United States, and it still exists today, and is known as the Howard University Hospital, which is one of three remaining historically-black hospitals in the United States.

Black hospitals founded before the U. S. Civil War include:

[24] The first annual meeting of the American Medical Association was held in 1848.

Howard University Hospital- founded in 1862

Black hospitals founded after the U. S. Civil War include:

Richmond Community Hospital- founded in 1902

Nashville Community Hospital at Meharry- founded 1910

General Hospital (Newport News, VA)- founded in 1915

Community Hospital (Norfolk, VA)- founded in 1915

Memorial Hospital (Greensboro, NC)- founded in 1923

Riverside General Hospital (Houston, TX)- founded in 1925

Southwest Detroit Hospital (Detroit, MI)- founded in 1974

In 1865, Alexander T. Augusta was placed in charge of a Freedmen's Hospital in Savannah, GA and thus became the first African American to direct a U. S. hospital.

Also, during that same year (1865), John S. Rock, who was an African American physician, dentist, and lawyer, became the first African American admitted to practice law before the bar of the US Supreme Court; and also second black member of the Massachusetts Medical Society (mid-1850s).

C.

Race Discrimination in the American Medical Profession, 1866 to 1900

During the period of Reconstruction (1865 – 1877), racial discrimination against African American physicians was readily manifest in medical societies, medical schools, and healthcare facilities.

For instance, in 1869-70, three black physicians—Alexander Thomas Augusta, Charles Burleigh Purvis, and Alpheus W. Tucker—were denied admission to the Medical Society of the District of Columbia (MSDC).

Consequently, the U. S. Senate found that this Medical Society of the District of Columbia was guilty of race discrimination. Sen. Charles Sumner led a failed effort to revoke the congressional charter of the MSDC.

African American and other allied white physicians formed the National Medical Society (NMS) in Washington, D.C., but the all-White American Medical Association refused to recognize the NMS. Officially, the AMA claimed that "the consideration of race and color had nothing whatsoever to do with the decision"; however, observers believed race played a major role. At the same time, the AMA recognized the all-White Medical Society of the District of Columbia, even though it excluded African Americans from its membership.

In 1872, the American Medical Association reaffirmed its decision to not admit the Freedmen's Hospital (Howard University) and the National Medical Society to its membership. Nevertheless, African American physicians persisted and made notable achievements during the period 1866- 1900.

- 1870 Lincoln University Medical Department is established in Oxford, PA.

- 1872 Henry Fitzbutler is the first African American graduate of the University of Michigan Medical School.

- 1873 Susan Smith McKinney graduates from New York Medical College and Hospital for Women in 1870; McKinney became the first black woman to be certified as a physician.

- 1873 Straight University Medical Department is established in New Orleans, LA.

- 1874 Davis' 1873 proposal is adopted.

- 1876 The AMA's Illinois delegation includes Sarah Hackett Stevenson, the AMA's first woman member, and the AMA President implies in a speech that no African Americans have yet been accepted as members of the AMA.

- 1876 Meharry Medical College is founded.

- 1881 Charles B. Purvis is asked to assist with the care of President James A. Garfield, who had been shot by an assassin earlier.

- 1881 Charles B. Purvis is appointed surgeon-in-chief of Freedmen's Hospital; first African American civilian in the US to head a civilian hospital.

- 1882 Leonard Medical School of Shaw University is established in Raleigh, NC.

- 1883 The Journal of the American Medical Association publishes its first issue. AMA Past President Nathan Smith Davis is founding editor.

- 1884 The Medico-Chirurgical Society of the District of Columbia is founded by a biracial group of physicians.

- 1886 The Lone Star State Medical, Dental, and Pharmaceutical Association of Texas is founded.

- 1887 The Old North State Medical Society of North Carolina is founded.

- 1888 All members of AMA constituent state societies are deemed “de facto permanent [AMA] members.” The AMA may have gained its first African American members beginning this year.

- 1888 Henry Fitzbutler establishes, and is the first dean of, the Louisville National Medical College in Louisville, KY.

- 1889 Flint Medical College of New Orleans University is established in New Orleans, LA.

- 1889 Hannibal Medical College is established in Memphis, TN.

- 1891 Provident Hospital and Training School for Nurses (Chicago, IL) is founded by Daniel Hale Williams.

- 1892 Miles Vandahurst Lynk, a future NMA founder, publishes the first issue of The Medical and Surgical Observer, the first African American medical journal.

- 1893 Daniel Hale Williams performs first successful open heart surgery.

- 1895 The North Jersey National Medical Association of New Jersey is founded.

- 1895 The National Medical Association is established in Atlanta, GA.

- 1895 Knoxville College Medical Department in established in Knoxville, TN.

- 1896 Austin Maurice Curtis, a protégé of Daniel Hale Williams, is appointed to the surgical staff of Cook County Hospital, the first such appointment to a non-segregated hospital.

- 1899 Chattanooga National Medical College is established in Chattanooga, TN.

- 1899 State University Medical Department is established in Louisville, KY.

- 1900 Second black medical journal, the Hospital Herald, first published in Charleston, SC.

- 1900 Knoxville Medical College is established in Knoxville, TN.

- 1900 University of West Tennessee College of Medicine and Surgery is established in Jackson, TN.

- 1900 Medico-Chirurgical and Theological College of Christ's Institution is established in Baltimore, MD

D.

Race Discrimination in the American Medical Profession, 1901 to 1970

In 1906, the American Medical Association first included African American physicians on its national membership roster, the *American Medical Directory*, but placed the words "colored" after their names. This policy was discontinued in 1939.

In 1909, *The Journal of the National Medical Association* publishes its first issue. NMA Past President Charles V. Roman is the first editor.

In 1913, Daniel Hale Williams becomes a charter member of the American College of Surgeons; the first African American to do so.

In 1932, the notorious syphilis experiment on black men begins. The U. S. Public Health Service Study of Untreated Syphilis in the Negro Male (Tuskegee Syphilis Study) continued for 40 years. (In 1936, the *Journal of the AMA* publishes the first academic journal article on the US Public Health Service Study of Untreated Syphilis in the Negro Male.)

In 1934, Louis T. Wright becomes the second African American physician admitted into American College of Surgeons; Wright is the only black member of the ACS at this time.

In 1938, for the first time, the National Medical Association's representatives Clarence H. Payne, Roscoe C. Giles, and Carl Roberts were recognized by the AMA House of Delegates and Board of Trustees for the first time to discuss issues of race discrimination in medicine.

In 1939, the Medical Society of the State of New York proposes that the AMA declare "that membership in the various component county societies of the [AMA] should not be denied to any person solely on the basis of race, color or creed." The AMA House of Delegates rejects the proposal because progress is reportedly being made and that membership matters are controlled by constituent societies.

In 1939, the AMA House of Delegates adopts a policy discouraging racial discrimination in constituent society membership, but notes that it cannot control the membership policies of its constituent societies.

During the World War, 1940-1943, the NMA meets with US Army and Navy to petition for the introduction of African American physicians into the US armed forces. 300 African American physicians are initially called to serve in 1941.

In 1941, Charles R. Drew is named director of the first American Red Cross Blood Bank and assistant director of blood procurement for the National Research Council.

In 1942, Maj. Gen. James C. Magee, Surgeon General of the US Army, racially segregates blood donated to the American Red Cross. These actions are denounced by several groups including the NMA, AMA and NAACP.

In 1942, the New York County Medical Society denounces the *Journal of the AMA* for printing "ads specifying religious or racial qualifications for medical posts" in its "Physicians Wanted" columns; similar ads are hereafter barred from being printed in the Society's weekly journal.

In 1944, the NMA argues that insofar as medical societies, "particularly in the South," continue to "exercise a bar to the membership of Negro physicians," the AMA should allow "members in good standing of the [NMA] to become members of the constituent societies of the [AMA]." The AMA House of Delegates rejects the proposal because membership matters are controlled by constituent societies.

In 1945, White physicians in Cincinnati, OH protest the Southern Medical Association's racial bars. In a letter, the physicians note that: "We would like to point out that in this community Negro physicians enjoy full parity with white physicians. Since your meeting is called a victory meeting, we feel that all groups of the American people who have made victory [in WWII] possible should be allowed to participate. To show racial discrimination is in our opinion contrary to the principles of democracy for which this war was fought and won."

In 1945, the National Medical Association, the NAACP, the Brotherhood of Sleeping Car Porters, National Negro Publishers' Association, Alpha Kappa Alpha sorority's National Non-Partisan Council, and Maj. Gen. Paul R. Hawley, Surgeon General of the Veterans Administration, protest the erection of segregated VA facilities.

In 1945, George D. Thorne, a prominent black surgeon in New York, is rejected by the American College of Surgeons because "fellowship in the college is not to be conferred on members of the Negro race at the present time."

In 1945, Louis T. Wright and other black and white physicians protest the racially exclusive policies of the American College of Surgeons and other specialty boards, forcing some of them to desegregate.

In 1945, 26 of the 78 accredited medical schools are closed to African American students entirely. All 26 are in Southern or border states.

In 1947, 27 of the 127 Veterans Administration hospitals maintain segregated wards; 19 of these 27 refuse to admit African American patients except for emergency treatment.

In 1948, the Medical Society of the State of New York proposes that: "No component society of the [AMA] shall exclude any qualified physician from its membership by reason of race, creed or color." However, the AMA House of Delegates rejects the proposal because membership matters are controlled by constituent societies.

In 1949, the Medical Society of the State of New York proposes that the AMA "appoint a committee to study the matter of membership in the [AMA], where such membership is banned for other than professional or ethical reasons." The AMA House of Delegates replies that the "manner of admission to membership is entirely a county society function, and unless the [AMA] Constitution and By-Laws were amended, the appointment of such a committee would serve no useful purpose."

In 1949, Medical Society of the State of New York elects Peter Marshall Murray to the AMA House of Delegates; first African American to be elected to the House.

In 1949, Missouri State Medical Association deletes the word "white" from its membership policies. The St. Louis Medical Society admits its first black member.

In 1949, the NMA petitions the Association of American Medical Colleges to publicly oppose race discrimination in medical schools and unequal opportunities in premedical education; AAMC responds that it lacks the jurisdiction to do so.

In 1950, after discussions with the New York State Commission Against Discrimination, the AMA eliminates designations of race, creed, and color from its "Situations Wanted" ads published in the *Journal of the AMA*.

In 1950, the House of Delegates passes a resolution proposed by the AMA's Virginia delegation urging component societies to study race discrimination in membership in "light of prevailing conditions … taking

such steps as they may elect to eliminate such restrictive provisions." The AMA emphasizes that membership matters are controlled by constituent societies.

In 1950, Peter Marshall Murray of New York becomes the first African-American to serve in the AMA House of Delegates; Murray serves for 12 years.

In 1951, National Association of Colored Graduate Nurses merges with the American Nurses Association.

In 1951, the Medical Society of Arlington County, VA, votes to desegregate.

In 1951, the Medical Society of the District of Columbia desegregates.

In 1951, the Medical Society of the State of New York proposes that the AMA "organize and make available to interested constituent state associations and component county societies, for their guidance and assistance, all pertinent information and experiences bearing on possible restriction to membership based on race or religion." The AMA House of Delegates rejects the idea because "progress" is reportedly being made and membership matters are controlled by constituent societies.

In 1952, Bibb County Medical Society of Georgia grants full membership to black physicians.

In 1952, Old North State Medical Society appeals for admission to the AMA as a constituent association. Although endorsed by the AMA's North Carolina delegation, the AMA House of Delegates votes to deny the request.

In 1953, Pulaski County Medical Society of Arkansas votes to desegregate.

In 1953, Alabama Medical Association unanimously votes to bar race discrimination in its affiliate county bodies.

In 1954, the Medical Society of the State of North Carolina votes to remove racially restrictive membership policies.

In 1954, Virginia Medical Society votes to remove racially restrictive membership policies.

In 1955, Veterans Administration orders all of its facilities to desegregate.

In 1956, the Clarkdale and Six Counties Medical Society of Mississippi admit their first African American physician into membership.

In 1956, the Medical Society of the State of North Carolina begins to admit African Americans as "scientific members."

In 1956, the Fulton County Medical Society votes down a proposal to admit African Americans as full members.

In 1956, Louisiana is the only Southern state without at least one black physician member of a local medical society.

In 1957, William Montague Cobb organizes the first Imhotep National Conference on Hospital Integration. Sponsors include the NMA, the Medico-Chirurgical Society of the District of Columbia, and the NAACP.

In 1960, 12 of the 26 medical schools in the South are closed to African American students.

In 1961, eight African American NMA members—F. Earle McClendon, Louis F. Reese, John T. Gill Jr., Albert M. Davis, George C. Lawrence, James P. Ellison, Roosevelt P. Jackson, and Clinton P. Warner—are

registered as delegates to the annual meeting of the Atlanta Graduate Assembly, held under the auspices of the Fulton County Medical Society. Although invited to attend the business functions, an Assembly spokesman notes that the Biltmore hotel dining room is whites-only. After attempting to be seated in the dining room, the NMA members are arrested.

In 1961, the AMA Board of Trustees requests that the House of Delegates take "official note of the progress that has been made toward eliminating race restrictions on constituent society membership and commends those societies which have moved forward in this area of human relations by taking positive actions to remove limitations on membership based on race or color."

In 1963, the Medical Committee for Human Rights is founded; MCHR provides medical care to civil rights workers, community activists and volunteers, and develops rural and mobile health centers.

In 1963, the AMA opposes pending Medicare legislation, while the NMA supports it.

In 1963, the AMA-affiliated Rhode Island Medical Society proposes excluding discriminatory societies from the AMA, but the idea is rejected for reasons that had remained unchanged for decades: "progress" is already being made and membership matters are controlled by constituent societies.

In 1963, Medical Committee for Human Rights, NMA, NAACP send an "Appeal to the AMA" to "speak out" against segregation, the Hill-Burton Act's "separate-but-equal" clause, and "the racial exclusion policies of State and County medical societies."

In 1963, 20 Black and white physicians from the Medical Committee for Human Rights and other prominent white and black organizations picket the AMA annual meeting. The AMA Board of Trustees chairman Hopkins responds that the picketing serves only "to obscure the achievements in medical science being reported at the meeting."

In 1964, in the case of *Simkins v Moses H Cone Memorial Hospital,* the US Fourth Circuit Court of Appeals finds it unconstitutional to practice race discrimination in federally-funded hospitals.

In 1964, the AMA urges Congress to amend the Hill-Burton hospital construction act such that "participation of a private hospital in the Hill-Burton program does not in any way change the private character of the hospital in any respect other than outlawing" race discrimination. The NMA believes that the AMA's proposed amendment is unnecessary and that it would perpetuate racism and weaken "the impact of the [1964 Simkins v] Moses Cone decision."

In 1964, Medical Society of the State of New York proposes "That the [AMA] go on record as being opposed unalterably to any discrimination in the field of medicine because of race, creed, color, or national origin, whether in patient care, physician opportunity, or professional organization."

In 1964, the AMA's California delegation proposes the AMA Board of Trustees formulate "mechanisms and procedures which will assist in the removal of any barriers to the acceptance of physicians on staffs and by component medical societies because of race, color, creed, or national origin" and that the Board instruct "all appropriate divisions, councils, and committees of the Association" to initiate a study on in order to determine the scope and extent of discriminatory practices which affect physicians."

In 1964, the State Medical Society of Wisconsin proposes that the AMA Board of Trustees "deny the rights and privileges of membership in the [AMA] to members of any constituent association or component society thereof which denies membership to any qualifies physician because of race, religion, or place of national origin."

In 1964, a resolution passes stating that the AMA is "unalterably opposed to the denial of membership in county medical societies" based on race, but without enforcement provisions.

In 1964, twenty-three sit-in demonstrators are arrested at the Heart of Atlanta Hotel, which refused to drop its color bar. Demonstrators include C. Miles Smith, a dentist and president of the NAACP's Atlanta chapter, and Clinton Warner, a surgeon and NAACP vice-president.

In 1964, the AMA-NMA Liaison Committee formed.

In 1964, after nearly a decade of litigation, Hubert A. Eaton gains staff privileges at James Walker Memorial Hospital in Wilmington, NC.

In 1965, Medical Committee for Human Rights holds its first national convention.

In 1965, in order to ensure compliance to Title VI, the Department of Health, Education and Welfare propose requiring physicians receiving federal funds to sign statements of compliance, formally forswearing racially discriminatory practices. There is "bitter" opposition to such a statement within the AMA's House of Delegates. This "oath of compliance" is regarded by the AMA as excessive, demeaning, and even discriminatory against physicians.

In 1965, the Medical Committee for Human Rights member Paul Lowinger records his experiences caring for those injured by violent segregationists on the Selma to Montgomery march. The *Journal of the AMA* reportedly accepts his letter for publication on April 29, but three weeks later informs him it will not be published due to its "controversial" nature.

In 1965, Medical Society of the State of New York proposes that the AMA admit African American "physicians who have thus been denied county medical society membership and thereby are unable to join certain hospital staffs or specialty organizations requiring [AMA] membership." The AMA House of Delegates does not adopt this resolution, but reaffirms its position of 1964.

In 1965, approximately 200 black and white demonstrators including the Medical Committee for Human Rights and NMA picket the AMA annual meeting, urging the AMA to "Integrate All County and State Medical Societies!" and "End Discrimination in Medicine Now!"

In 1965, Title VI of the Civil Rights Act of 1964 makes discrimination in hospitals receiving Federal funds illegal.

In 1965, Passing of Medicare and Medicaid legislation essentially mandates hospital integration.

In 1965, the National Medical Association leaders resume Liaison Committee activities with AMA leaders.

In 1966, due to objections from the AMA, the Department of Health, Education and Welfare notes that signing an "oath of compliance" to Title VI of the Civil Rights Act of 1964 is not necessary for physicians.

In 1966, the AMA's Connecticut, California, New Hampshire, and New York delegations proposes excluding discriminatory societies from the AMA.

In 1966, the AMA's New York and New Jersey delegations propose that "No applicant for membership [in a state or local society] shall be barred because of his race, color or creed," and "If admission to membership is denied by the constituent association, he shall have the right of appeal to the [AMA] Judicial Council."

In 1966, the AMA House of Delegates declares that its "[Judicial] Council shall have jurisdiction to receive appeals filed by applicants who allege that they, because of color, creed, race, religion, or ethnic origin, have been unfairly denied membership in a component and/or constituent association, to determine the facts in the case, and to report the finding to the House of Delegates."

In 1966, the AMA's Pennsylvania delegation proposes the AMA "ascertain whether or not there is any evidence of discrimination in county or state medical societies." The AMA House of Delegates replies that the resolution "would impose an impractical burden upon the staff to require an investigation to determine whether discrimination exists, in the absence of specific complaints." Instead, the AMA reaffirms the 1964 policy.

In 1966, approximately 400 white and black demonstrators including the Medical Committee for Human Rights, NMA and NAACP picket the AMA annual meeting.

In 1968, Massachusetts Medical Society proposes that the AMA amend its Constitution and Bylaws, to give the Judicial Council the authority to expel constituent societies for race discrimination in membership policies. The AMA House of Delegates adopts the resolution.

In 1968, reaffirmation of cooperation between AMA and NMA and restatement/strengthening of AMA policy to "continue to use all of its influence to end discriminatory racial exclusion policies or practices by any medical society." Additionally, first mention by AMA of seeking ways to increase the presence of African Americans in medicine.

In 1968, Members of the Medical Committee for Human Rights and the Poor People's Campaign picket the AMA annual meeting to protest

insufficient AMA action on race discrimination and health services for the poor.

In 1968, Association of American Medical Colleges recommends that "medical schools must admit increased numbers of students from geographical areas, economic backgrounds and ethnic groups that are now inadequately represented."

In 1968, over three-fifths (61.77%) of the African Americans enrolled in US medical schools for the class of 1969 are being trained at either Howard University Medical School or Meharry Medical College.

Throughout the 1950s and 60s, the American Medical Association resisted petitions and pressure from the National Medical Association and other civil rights groups to adopt anti-discrimination and desegregation policies.

When the Civil Rights Act of 1964 was being debated, the AMA remained silent and refused to endorse changing the "separate but equal" provisions of the Hill-Burton Act.

E.

Race Discrimination in the American Medical Profession, 1970 to Present

During the past 50 years, the American medical profession has continued to reap the whirlwind of past racial discrimination within that profession.

In 1989, the AMA report on "Black-White Disparities in Health Care" issued.

In 1992, the AMA Minority Affairs Consortium created.

In 1994, Lonnie Bristow, M.D., became the first African American President of the AMA.

In 1995, the AMA House of Delegates adopted a report on Racial and Ethnic Disparities in Health

Care. Recommendations included "That the American Medical Association maintain a position of zero tolerance toward racially or culturally based disparities in care," among additional provisions.

In 2004, the Commission to End Healthcare Disparities was established by the NMA, NHMA, and the AMA. The goals of this commission were:

- Influencing government actions to curtail disparities;
- Engaging health professionals and organizations in efforts to eliminate disparities;
- Improving the practical environment to foster effective efforts to eliminate disparities;
- Promoting collaboration between medicine and private industry on strategies to eliminate disparities
- Increasing diversity in the health professional workforce
- Reform the Medicare physician payment system
- Reform the medical liability system
- Improve the quality and safety of health care
- Improve public health through healthy lifestyles, disaster preparedness, and reducing health disparities.

In 2005, the AMA Institute for Ethics invited a panel of experts to review and analyze the historical roots of the black-white divide in U.S. medicine and resulted in an in-depth article, published in JAMA in 2008, that explored racism and racist practices at the AMA beginning with its founding in 1847.

In 2008, the AMA made a formal apology for its past discrimination and former AMA President Ronald M. Davis, MD, discussed historic harms committed against Black physicians and patients. Dr. Davis also addressed the National Medical Association membership (PDF) and noted "our apology is a modest first step toward healing and reconciliation."

In 2019, the AMA launches its Center for Health Equity upon hiring its first chief health equity officer to embed health equity across the organization and work to eliminate health inequities that are rooted in historical and contemporary injustices and oppression in medicine and the health system.

In 2021, the AMA removes bust of Dr. Nathan Davis, one of the founders of the AMA, from public display and acknowledges his role in blocking integration and promoting and embedding racism in the AMA.

As the third decade of the twenty-first century evolves, innumerable structural problems that foment racist discriminatory practices persist within the health care industries. In "Discrimination Toward Physicians of Color: A Systematic Review," J Natl Med Assoc. 2020 Apr, 112(2): 117-140, authors Filet, Alvarez and Carnes concluded:

> With physicians of color comprising a growing percentage of the U.S. physician workforce, healthcare organizations must examine and implement effective ways to ensure a healthy and supportive work environment….
>
> After removal of duplicates, our search retrieved 607 studies published between 1990 and 2017. We excluded 395 studies after reviewing titles and abstracts and conducted full-text reviews of the remaining 215 studies, excluding 196 for reasons outlined in Figure 1. Manual bibliographic and author searches identified an additional 3 studies. The final data set consisted of 19 studies that reported on ethnic or racial discrimination experienced by physicians of color who practice in the U.S. …

Survey results confirmed the high prevalence of discrimination toward physicians of color and qualitative studies were replete with personal anecdotes of subtle and overt discrimination. In studies that included different ethnic/racial groups, **black physicians consistently encountered discrimination at higher rates than any other group**….

Qualitative studies provided detailed examples of discrimination experienced by physicians of color and descriptions of feeling isolated, alone, invisible, and treated like an outsider. Many shared examples of overtly prejudiced statements or conscious discriminatory acts stated outright by the offender to be race- or gender-based. More frequent, however, were subtle practices of discrimination in the form of inadequate institutional support, exclusion from social networks, devaluation of research on minority health or health disparities, and a lack of institutional commitment to advancing diversity. Physicians of color described facing greater scrutiny, being held to higher standards, having their competence questioned, needing to justify their credentials, and being mistaken for maintenance, housekeeping, or food service workers in the workplace….

In spite of frequent and persistent experiences with race-based discrimination, participants described the silence of others in their institution around race generally and around their experiences of discrimination specifically, in conjunction with an inability to raise the issue themselves for fear of repercussions. These fears may be justified as Coombs and King, the only study to ask about reporting episodes of discrimination and the institutional response, found of the 50 respondents who made a formal complaint of discrimination, 50% reported no change and almost 20% reported worsening of the situation. Among physicians of color, 62.5% (105/168) were more likely to report no change in their situation when they filed a complaint about discrimination compared to 37.5% (109/277) of white physicians….

Only 1 of the 6 survey studies specifically asked about discrimination from patients. In that study of 529 physicians,

> significantly more black (60%) than any other ethnic/racial group agreed or strongly agreed that "patients have refused my care"....
>
> In addition to statements about patients' refusal of care and mistrust, several physicians of color reflected on positive aspects of their ethnic/racial identity in patient interactions in feeling they were giving back to their community and able to connect with or advocate for patients from marginalized groups....
>
> Our review suggests multiple directions for future research beginning with an assessment of healthcare organizations' current policies to protect physicians of color from discrimination with data on their effectiveness. Also needed is exploration of legal recourse for physicians of color if healthcare organizations tie their pay to patient satisfaction scores and if this systematically results in lower pay for physicians of color than their white counterparts. The existence of daily workplace indignities experienced by physicians of color needs no further evidence. It is time to develop interventions informed by existing research and test their effectiveness on reducing workplace discrimination towards physicians of color from leaders, colleagues, and patients; enhancing perceptions of workplace climate; and improving employment outcomes. As stated by the National Academy of Medicine, reducing the negative impact of cultural stereotypes in physician-patient interactions will benefit both the patient and the physician.

In "**An Epidemic of Racism in Peer Review: Killing Access to Black and Brown Physicians**," Journal of Health and Life Sciences Law (May 2022, Vol. 16: Issue 1), authors Sidney Welch and Tricia Hoffler, concluded:

> Medicine is not immune to the larger societal ills. The past few years have shined a spotlight on racial inequities, leading the American Public Health Association, American Academy of Pediatrics, and the American Medical Association, among others,

> to publicly declare that racism is a public health crisis and to suggest redress in a myriad of different ways.
>
> Mirroring this national crisis at a focused level, the health law bar and the media have reported a significant increase in the number of adverse medical staff actions against physicians of color—raising a question among some physicians whether this increase is attributable to an increase in medical staff actions motivated by racism or an increase in the number of physicians of color coming forward to challenge some of these actions. Nonetheless, it is **a crisis of epidemic proportions** and impact, threatening the **economic, physical, and mental well-being of African American physicians**, often with **devastating impacts to the availability of care to many already underserved patients** in this country.

In their assessment of the peer review process and procedure, authors Welch and Hoffler noted:

> [B]ecause of the subjective nature of peer review and the "metrics" used in such review, the process is too often replete with unconscious bias and economic, racial, and other improper motivations. Hospitals have a vested interest in the quality of care that physicians on their medical staff provide. Under the operating principle that physicians and health care professionals are best qualified to evaluate the quality of medical care, the governing boards of hospitals delegate this responsibility to the medical staff, although they may not abdicate their responsibility entirely. Peer review is one component of that quality assurance. As its name indicates, this self-regulatory review should be conducted by peers of the affected physician with clinical knowledge in the relevant specialty. However, this term arguably should be extended beyond **"peer"** in the clinical sense to include **racial and ethnic peers** due to concerns regarding implicit bias and micro and macroaggressions discussed herein....
>
> Hospitals can take action against a physician's medical staff membership and clinical privileges for a variety of reasons

> including "disruptive" behavior, quality of care and competency concerns, lack of required certifications or other qualifications designated by the medical staff bylaws or privileges delineation, failure to meet record keeping requirements, unprofessional conduct, and geographic proximity of the physician's residence to the hospital, just to name a few. Too often these reasons are a pretext for racism, and concerns regarding "negligent credentialing" become a crutch to justify actions taken against medical staff that are racially motivated.

Because the present status of state and federal laws regulating health care and the licensing or authorization of medical privileges of physicians often ignores the unique plight of African American physicians and the patients of color whom they serve, the United Physicians' Alliance, Inc. relies upon the 13th Amendment, U. S. Constitution— and its proscriptions against the "badges and incidents" of slavery AS IT RELATES to the provision of medical services by and to African Americans— together with its implementing statutory regulations, such as 42 U. S.C. Sec. 1981, to address and rectify these racial inequities within the medical services and healthcare industry.

CONCLUSION

We trust that this online material has been informative and helpful. The United Physicians' Alliance, Inc. is available to serve.

Please do not hesitate to contact us if you need additional information, or if we may be of further assistance.

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