

Segregation, Civil Rights, and Health Disparities: The Legacy of African American Physicians and Organized Medicine, 1910-1968

Harriet A. Washington; Robert B. Baker, PhD; Ololade Olakanmi; Todd L. Savitt, PhD; Elizabeth A. Jacobs, MD, MPP; Eddie Hoover, MD; Matthew K. Wynia, MD, MPH; for the Writing Group on the History of African Americans and the Medical Profession

Between 1910 and 1968, the National Medical Association (NMA) repeatedly clashed with the American Medical Association (AMA) over the latter organization's racial bars to membership and other health policy issues. The NMA, founded in 1895 as a nonexclusionary medical society to provide a voice for disenfranchised black physicians and patients, struggled in its early years, during which AMA leadership took scant notice of it. But skirmishes ensued over such actions as stigmatizing racial labels in the AMA's *American Medical Directory*, which, beginning in 1906, listed all US physicians but designated African Americans with the notation *col*. The NMA also repeatedly asked the AMA to take action against overt racial bars on blacks' membership in its constituent state and county societies. During the civil rights era, African American physicians received no AMA support in seeking legal remedies to hospital segregation. And the NMA and AMA found themselves opposed on other policy issues, including Medicaid and Medicare. These differences eventually catalyzed a series of direct confrontations. The 1965 AMA meeting in New York City, for example, was protested by about 200 NMA-led picketers. The NMA's quest for racial equality in medicine was supported by some other medical organizations, such as the Medical Committee for Human Rights. In 1966, the AMA House voted to amend the AMA Constitution and Bylaws, giving its Judicial Council (now the Council on Ethical and Judicial Affairs) the authority to investigate allegations of discrimination. This paved the way for a subsequent era of increasing cooperation and understanding.

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Author Affiliations: DePaul University College of Law, Chicago, Illinois (Ms Washington, visiting scholar); The Union Graduate College-Mount Sinai School of Medicine Bioethics Program, and Department of Philosophy, Union College, Schenectady, New York (Dr Baker); Institute for Ethics, American Medical Association, Chicago, Illinois (Dr Wynia and Mr Olakanmi); Department of Medical Humanities, Brody School of Medicine, East Carolina University, Greenville, North Carolina (Dr Savitt); Collaborative Research

Unit, Cook County Hospital, and Rush Medical School, Chicago, Illinois (Dr Jacobs); National Medical Association, Washington, DC (Dr Hoover, editor, *Journal of the National Medical Association*); The University of Chicago Hospitals, Chicago, Illinois (Dr Wynia).

Corresponding Author: Matthew K. Wynia, MD, MPH, Institute for Ethics, American Medical Association, 515 N State St, Chicago, IL 60654 (matthew.wynia@ama-assn.org).

INTRODUCTION

A legacy of segregation haunts American medicine. This legacy emanates, in part, from a history of discriminatory policy decisions made by the American Medical Association (AMA) and its constituent societies, history that was acknowledged by AMA leaders in a public apology in July 2008.¹ Beginning in 1870, for example, the AMA elected not to adopt policies banning racial and gender discrimination in membership and instead voted to allow discrimination in its constituent medical societies.² In the early 20th century, the AMA instigated and supported the Flexner report, which contributed to the evolution of medical education but also advocated separate and unequal medical education for “Negro physicians” while successfully urging the closure of most African American medical schools.^{2,3}

These and other events early in the development of the American medical profession posed severe challenges to African American physicians and provided impetus for an era of increasing activism—namely, the civil rights era—that eventually changed both AMA policies and American medicine. But even with more recent civil rights victories, the intentional exclusion of African Americans from mainstream organized medicine for almost a century contributed to tremendous harms with ongoing repercussions in the African American community.

In this and several other papers on these topics (see Table 1 and other materials available at <http://www.ama-assn.org/go/AfAmHistory>), our aim is to bring this painful but important history into the open. We hope that doing so will facilitate dialogue, healing, and unified action across the medical profession to address our nation's health care problems, especially the health care

inequities that disproportionately harm African Americans today.

In a prior publication, we provided a concise summary of the panel's finding across the entire period, 1846-1968.² An earlier *Journal of the National Medical Association (JNMA)* publication provided a more detailed look at several key events during the period 1847-1910.⁴ The present report examines some important events during the period 1910-1968, during which time the AMA and NMA repeatedly clashed over racial bars to membership and other important health policy issues.

METHODS

The Institute for Ethics at the AMA invited an independent panel of experts to review and analyze the historical roots of the racial divide within American medical organizations. Panel members were initially selected by Institute for Ethics staff, but additional members were then added by the panel. The panel was convened with the support of NMA and AMA leadership, but neither was asked to approve the members of the panel nor the contents of the resulting manuscripts prior to submission.

For source materials, the panel examined primarily AMA, NMA, and newspaper archives, the latter via online databases (such as <http://www.accessible.com>, <http://bsc.chadwyck.com> and <http://www.proquest.com>). In addition, we searched Medline using keywords *race*; *segregation*; *integration*; and the Mesh heading, *prejudice*. A number of books were especially useful and are listed in a bibliography at the project Web site.

The panel decided to avoid making moral judgments about the intent and motivations of actors in this history. Often, motivations are mixed or obscured, even to the actors themselves. More clear are the results of decisions, which is where the panel elected to focus its attention. Some broader social historical context is provided both here and in supplemental materials available on the project Web site; however, space constraints and the lim-

its of our project preclude a full explication of the many sociopolitical factors that may have been reflected in the historical episodes we describe.

The Col. Designation in the American Medical Directory

The NMA was founded in 1895 as a nonexclusionary medical society to serve as a voice for African American physicians and patients, but the organization was very small and struggled in its early years, even though it attempted to expand its membership by being open to dentists and to non-African Americans. Still, it was able to meet in only 5 of its first 10 years of existence.⁵ AMA leaders meanwhile ignored, or were perhaps unaware of, the existence of the NMA. Prior to World War II, the NMA and the plight of the physicians and patients it served were almost never mentioned in AMA records. For instance, when the NMA is mentioned in 1931 in the minutes of an AMA Board of Trustees meeting, it is accompanied by a phrase explaining that it is "the Negro's [sic] organization," suggesting perhaps that there was little knowledge of the NMA within the AMA board.⁶

One of the first documented NMA-AMA interactions involved the AMA's *American Medical Directory*, which listed all US physicians, AMA members, and nonmembers alike. Since its first edition in 1906, the directory had listed African American physicians as *colored*, as designated by (*col.*) next to the physician's name.⁷ According to members of the NMA at the time, the (*col.*) designation was profoundly stigmatizing and

has worked several hardships on them; among other things, it has resulted in the cancellation of their malpractice insurance and in their being refused credit, particularly when they desire to purchase books and other things on the [installment] plan.^{8(p51)}

Table 1. Supplemental Reports^a

Report	Report Topic
A.	AMA Annual Meeting Attendance Roster (Civil War era), 1860-1868
B.	Exclusion of the National Medical Society of DC from the AMA, 1870-1872
C.	Seating Delegates from the Massachusetts Medical Society, 1870
D.	Evolution of AMA Membership Criteria, 1847-1981
E.	The AMA, NMA, and the Flexner report of 1910
F.	Racial Designations in the American Medical Directory, 1906-1940
G.	The AMA and the Hill-Burton Act of 1946
H.	The AMA and the Civil Rights Act of 1964
I.	The AMA and Medicare and Medicaid, 1965
J.	AMA Policies on Racial Discrimination in Constituent and Component Societies, 1870-1968
K.	Proposal to "Amalgamate" the AMA and NMA, 1973

^a These supplemental reports (available on the project Web site: <http://www.ama-assn.org/go/AfAmHistory>) provide additional detail and direct quotations from primary source materials on specific aspects of the history of African American physicians and the American Medical Association.

Despite a request from the NMA, the AMA Board of Trustees in 1931 refused to meet with an NMA delegation on the issue and did not “feel disposed to make any change in its...policy of designating colored physicians.”⁶ But the NMA persisted and in 1938 the AMA board met in Chicago with an NMA “special committee,” comprising Drs Roscoe C. Giles (former president of NMA), Clarence H. Payne (NMA Commission on Tuberculosis), and Carl G. Roberts (former president of NMA)—each of whom was from Chicago and a member of the AMA—to hear their concerns about the directory’s system of designating race.^{8(pp48,49)} A protracted correspondence ensued, and by 1939 the issue had begun to attract publicity, especially following an NMA meeting held in New York City in August 1939.⁹ According to the minutes of a September 1939, AMA board meeting, “in most of that publicity [from the August NMA meeting] the American Medical Association has been put in the unenviable position of having refused membership to the Negro physicians and of having set them apart as colored.”¹⁰ In light of this, the AMA board voted to drop the designation from subsequent editions of the directory.

Rejecting Racism in Principle, Reaffirming Jim Crow in Practice

By the 1930s, segregation—enforced by Jim Crow laws—had permeated all areas of American life.¹¹ After 1888, all members of state and county societies were automatically considered members of the AMA, thus the AMA had some African American members, via integrated medical societies, from that time forward. But still, by 1938, African American physicians comprised only approximately 0.3% of AMA members, according to the *American Medical Directory* of the time. Overt racial bars on membership in many state and local societies—especially but not exclusively in the south—precluded most African American physicians from joining the organization.^{2,4}

Exclusion from local and state medical societies had significant implications for physicians of this era, well beyond the fact that it precluded membership in the AMA and even beyond those mentioned in our earlier publications.^{2,4} For example, medical society membership in this era became a de facto requirement for obtaining specialty training. In general, a physician needed to have admitting privileges at a hospital to be accepted into a specialty training program. But admitting privileges often hinged on local medical society and/or AMA membership.^{12,13} Thus, African American physicians were functionally excluded from specialty training because of their exclusion from local and state societies.^{14,15} In 1931 there were approximately 25 000 specialty board-certified physicians in the United States. Only 2 of them were African American: Dr Daniel Hale Williams of Chicago, a remarkable physician on many counts who was a cofounder of the NMA, a member of the AMA, and a charter member of the American Col-

lege of Surgeons;¹⁶ and Dr William Harry Barnes, another famous physician, who was a 1927 diplomat of the American Board of Otolaryngology.¹⁷

While the issue of specialty training for African Americans had received little, if any, notice within the AMA’s leadership up to this period, opening discussions with the NMA about the directory created important new channels of communication. In 1939, with a supporting resolution from the AMA’s all-white New York delegation, the AMA board appointed a subcommittee to consider “certain problems...inimical to the welfare of colored physicians and the people whose medical welfare they have at heart.”^{18(pp74,86)} According to the AMA board, however, the first of these “problems” was “[t]he erroneous impression created by publicity bearing on the question of membership in the [AMA].”^{18(p86)} A 1939 report on the membership issue admonished discriminatory practices at state and local societies, asserting that “membership in the various component county societies should not be denied to any person solely on the basis of race, color or creed.”^{18(p86)} However, the report—adopted by the AMA House of Delegates—also declared that “every component county medical society has the right of self government in local matters and membership.”^{18(pp86-87,90)} Thus, in principle, after 1939 the AMA had a policy recommending nondiscrimination; in practice, however, each constituent society of the AMA could discriminate at its discretion.

This argument reflected similar reasoning being used to excuse “states’ rights” to implement racial segregation throughout all reaches of life, and it remained powerful within the AMA for decades, despite numerous creative attempts to circumvent its effects. For instance, in 1944 NMA representatives directly appealed to the AMA to address locally imposed barriers to membership in the AMA. The NMA noted that African Americans had served with distinction in World War II and yet medical societies, “particularly in the South,” continued to “exercise a bar to the membership of Negro physicians.”^{19(p82)} The AMA, they argued, should allow “members in good standing of the [NMA] to become members of the constituent societies of the [AMA]” and, if that were not to occur, that members of the NMA should be allowed direct, “associate membership,” in the AMA.^{19(p82)} The AMA board “studied the [NMA’s request] with interest and sympathy” and, as in 1939, “urge[d] component societies to extend all aid that is practical to the Negro physicians in their communities.”^{19(p83)} However, as it had in 1939, the AMA house asserted as an immutable fact that “membership in the component county medical societies...is outside the jurisdiction of the [AMA].”^{19(p83)} The option of changing the bylaws of the AMA to address the issue was not mentioned as an option.

Fresh Determination to Fight Segregation

Following World War II an increasing number of physicians, both white and black, found condemnation of racial

segregation without action insufficient. This mirrored changes happening throughout the nation. According to historian C. Vann Woodward, “American [World War II] propaganda stressed above all else the abhorrence of... Hitler’s brand of racism and its utter incompatibility with the democratic faith.”^{21(pp130-134)} For many Americans, however, the Holocaust raised awareness of inherent similarities between “Hitler’s brand of racism” and white-supremacist ideologies in the United States, replete with the lynchings and other atrocities they produced. Partly because of this moral crisis, argues historian Manning Marable, “[b]lack and an increasing sector of liberal white America came out of the war with a fresh determination to uproot racist ideologies and institutions at home.”²⁰

In medicine in the late 1940s and 1950s, several constituent societies of the AMA, including some in the south, opened their doors to African Americans for the first time. And progressive black and white physicians fought to integrate racially exclusive medical specialty boards.^{21(pp132-136)} In 1950 Peter Marshall Murray (1888-1969) became the first African American to serve in the AMA House of Delegates (Figure 1).^{21(p163),22,23} Murray noted that at least some African American physicians had been “admitted to membership in some county societies” in most southern states by 1955 (the exceptions were Mississippi and Louisiana).^{21(p134)} However, medicine remained almost entirely segregated in the north and south.^{13(p249)} In 1958 two-thirds of all African American physicians had received their training at Howard University or Meharry Medical College.²⁴ In fact, the number of African American medical students at “white” medical schools actually *declined* from 216 in 1955 to 164 in 1962.²⁵ And at the AMA, between 1944 and 1965, more than a dozen attempts to expand African American inclusion in the AMA were rebuffed due to insufficient support from within the AMA house, which then comprised (as it does today) representatives from all of the

Figure 1. Peter Marshall Murray (1888-1969), First African American Elected to the American Medical Association House of Delegates (1950-1961)^{11(pp119)}



states (Table 2). In 1952, for example, the Old North State Medical Society, a North Carolina medical society for black physicians, appealed for admission to the AMA as a “constituent association.” Although this idea was apparently endorsed even by the AMA-affiliated Medical Society of the State of North Carolina, the AMA house voted to deny the request.^{26(pp11-12)}

The Rhode Island Medical Society proposed excluding discriminatory societies from the AMA in 1963, but the idea was rejected on the basis that “progress” was being made in integrating southern societies. Additionally, it was noted—apparently without irony—that there were “a number of Negro members of state medical societies who [had] not chosen to become members of the [AMA].”²⁷ (Individual AMA dues had been instituted in 1950, marking the first time since 1888 that it was possible to join a state medical society without attaining membership in the AMA; However, the opposite still was not possible.) The possibility that some eligible African American physicians might elect not to join the AMA to protest how their southern brethren were treated was not mentioned. Yet among African American physicians, such refusals to join were not unknown, nor were they without consequence. As one such physician wrote in 1969, reflecting on his decision, “I refused to pay my \$100 dues to the AMA, and risked losing my hospital privileges, because I will not be a party to what is being done to my black brothers in the South by this organization.”²⁸ Sadly, because of the democratic nature of AMA decision making, driving African American (and progressive white) physicians away from membership presumably contributed to the organization’s relative silence throughout the civil rights era.

Hospital Desegregation

Early in the civil rights era, hospital desegregation was recognized as a key to African American physicians’ professional advancement. Board certification was becoming ever more important in validating specialty status and ensuring quality of care, as well as for financial reasons. Hospitals, by this time, had become the center of post-graduate specialty training and, hence, a gateway to board certification—and, as noted earlier, most hospitals required physicians to be members of local societies or the AMA as a precondition for obtaining staff privileges.^{29,30} A little progress had been made in the area of specialty training since 1931, when only 2 African Americans were specialty board certified. By 1958 there were 73 121 board-certified specialist physicians in the United States, of whom about 350 (<0.5%) were African American.^{21(p136),29(p320)} But still, as Reuben Kessell noted in 1954,

For most medical specialists, being on the staff of a hospital is an imperative for successful practice. Yet appointment decisions are not based solely on considerations of skill and talent, but

are similar to admissions procedures to a country club— race, religion, family, type of practice, and so forth are often important.”³¹

Recognizing this key barrier to both professional advancement and effective patient care, from the outset of the civil rights movement, African American physicians began a tenacious pursuit of legal remedies to hospital segregation.^{32,33} Hubert A. Eaton (1916-1991), for example, first sought to

Table 2. AMA Policies and Proposals to Address Racial Discrimination in Constituent Societies

Date	Policy/Policy Proposal	Response
1870	Sullivan, of Massachusetts, proposes “That no distinction of race or color shall exclude from the association [AMA] persons claiming admission and duly accredited thereto.”	Tabled (106 to 60)
1939	Flynn, for the Medical Society of the State of New York, proposes that “the House of Delegates of the American Medical Association declare its belief that membership in the various component county societies of the American Medical Association should not be denied to any person solely on the basis of race, color or creed.”	Reference Committee reports that “the resolution implies that the county medical society should not, in effect, have the right of selection of its own members, a fundamental principle in our organization. Readjustment along the lines of the resolution are rapidly taking place in those states most vitally interested. Your reference committee recommends that the resolution be not passed.” <i>Reference Committee report is adopted.</i>
1939	Following meetings with NMA leaders, a Board of Trustees report “reemphasize[d] the fact that membership in the various component county societies should not be denied to any person solely on the basis of race, color or creed,” and called attention “to the fact that there are now a large number of colored physicians in the membership of the American Medical Association,” and that “it is recognized that every component county medical society has the right of self government in local matters and membership.”	Report is adopted.
1944	A resolution was presented to the Board of Trustees by the NMA stating: “Resolved, That an appeal be made through the Board of Trustees and the House of Delegates of the American Medical Association to its constituent societies to continue and enlarge the opportunities for the elevation of the standard of medical practice among our Negro physicians by (1) Increasing municipal, county and state hospital facilities in which the Negro physician may practice; (2) allowing the members in good standing of the National Medical Association to become members of the constituent societies of the American Medical Association to the end that members of the National Medical Association, both South and North, may become members of the American Medical Association and thus enjoy the opportunities of the scientific features of the conventions and partake more fully of the benefits of organized medicine; (3) until such changes as are necessary in the constitutions of the constituent societies of the American Medical Association can be brought about in those constituent societies which now exercise a bar to the membership of Negro physician, that members of the Nation Medical Association be allowed the privilege of Associate Membership in the American Medical Association.”	Reference Committee reports that, “Your reference committee has studied the resolution of the National Medical Association with interest and sympathy. It feels that the Negro physicians of this country should be offered every possible opportunity to improve their medical qualifications. It would urge component societies to extend all aid that is practical to the Negro physicians in their communities to the end that the quality of service rendered by them to their people may be steadily improved. It is recognized, however, that the decision as to membership in the component county medical societies or on hospital staffs is outside the jurisdiction of the American Medical Association and is a matter of local concern.” <i>Reference Committee report is adopted.</i>

secure staff privileges and join the all-white medical staff of James Walker Memorial Hospital in Wilmington, North Carolina, in November 1954.³² After his initial letters and appeals were ignored, Eaton sued this public hospital. This ignited a 3-year legal battle that ascended to the US Supreme Court, in which Eaton lost. In early 1960 Eaton and 2 other African American physicians applied again for staff privileges. This time, they were sent applications, which they completed. When their applications were denied, they filed a second lawsuit in July 1961, which they again lost and appealed. In 1964, they finally won on appeal and gained staff privileges—after nearly a decade of litigation.^{21(pp246-253),32} We found no evidence that the AMA weighed in on this or any other hospital desegregation case.

The Struggle for Civil Rights

Outside the AMA many physicians played critical roles in civil rights battles. Physicians assumed visible

and vocal roles in the Medical Committee for Human Rights, the National Association for the Advancement of Colored People (NAACP), other advocacy groups, and, as Hubert Eaton’s case demonstrates, brought lawsuits that sought to end hospital segregation.¹³ Both black and white physicians organized and participated in civil rights marches and picket lines, rendering medical aid and writing about the sometimes-fatal violence perpetrated by segregationists and during riots.^{13,21(pp159-190, 260-8),34}

Many NMA leaders were critical players in these efforts. For example, as early as the 1950s, William Montague Cobb (1904-1990), editor of *JNMA*, included a column entitled the “Integration Battlefield,” which addressed civil rights struggles in the medical sphere (Figure 2). In 1957 Cobb organized the first Imhotep National Conference on Hospital Integration (Figure 3). Sponsors included the NMA, the NAACP, the National Urban League, and the Medico-Chirurgical Society of

Table 2. AMA Policies and Proposals to Address Racial Discrimination in Constituent Societies (cont)

Date	Policy/Policy Proposal	Response
1948	Medical Society of the State of New York proposes that the AMA constitution be amended so as to include that “No component society of the American Medical Association shall exclude any qualified physician from its membership by reason of race, creed or color.”	Reference Committee reaffirms “that the component medical society is the sole judge as to whom it elects to membership, provided the applicant shall meet the medical requirements for membership.” <i>Reference Committee report is adopted.</i>
1949	Monteith, of New York, proposes “that the House of Delegates of the American Medical Association be memorialized to appoint a committee to study the matter of membership in the American Medical Association, where such membership is banned for other than professional or ethical reasons, and to report back to this House.”	Reference Committee reports that: “After consideration of the resolution and discussion with those interested in it, the committee [Reference Committee on Executive Session] is of the unanimous opinion that the fundamental basis of organization of the American Medical Association is the component county society. The Constitution and By-Laws of the Association clearly express this intent. The manner of admission to membership is entirely a county society function, and unless the Constitution and By-Laws were amended, the appointment of such a committee would serve no useful purpose.” <i>Reference Committee Report is adopted.</i>
1950	Hutcheson, of Virginia, proposes that “the constituent and component societies having restrictive membership provisions based on race study this question in the light of prevailing conditions with a view to taking such steps as they may elect to eliminate such restrictive provisions.”	Reference Committee notes that, “This matter [membership in constituent societies] still remains under the control of constituent societies.” <i>Resolution is adopted.</i>
1951	Eggston, of New York, proposes that “the House of Delegates of the American Medical Association request the Secretary and the officers to collect, 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.”	Reference Committee reports that, “As this question is being considered in the communities involved and progress has been made, and since membership should be considered on a local, not a national level, your reference committee disapproves of this resolution.” <i>Reference Committee report is adopted.</i>

the District of Columbia.^{13(pp268-269),21(pp143-144).}

The AMA, in contrast, was often seen as uninterested in, or even as an obstruction to, the civil rights agenda. For example, although the AMA sent representatives to the first Imhotep conference, Cobb noted in 1958 that the AMA refused to “participate officially and actively” in subsequent meetings.^{21(pp143-144)} A series of further decisions illustrate the AMA’s unwillingness to take a public stand on civil rights issues.

- In 1961, the AMA elected not to defend 8 NMA physicians who had been arrested for asking to be

served at a Fulton County Medical Association luncheon in the whites-only section of Atlanta’s Biltmore Hotel cafeteria.^{13(pp264-265)}

- In 1965, future Medical Committee for Human Rights (MCHR) National Chairman Paul Lowinger recorded his experiences caring for those injured by violent segregationists on the Selma to Montgomery march. *JAMA*, which, at the time did not maintain editorial independence from the AMA as it does today, reportedly accepted his letter for publication on April 29, 1965, but 3 weeks later informed Lowinger that it would not be published

Table 2. AMA Policies and Proposals to Address Racial Discrimination in Constituent Societies (cont)

Date	Policy/Policy Proposal	Response
1952	Hill, of North Carolina, proposes that “the House of Delegates of the American Medical Association approve the recognition of the Old North State Medical Society [an African American medical society] as an affiliate of the Medical Society of the State of North Carolina, and also of the American Medical Association.” [Functionally, this would have allowed members of the Old North State Medical Society to become members of the AMA without also being members of the Medical Society of the State of North Carolina.]	The Board of Trustees recommends against the resolution, citing: lack of authority to create “affiliates;” no precedent for having two constituent associations in one state; “If a second constituent association composed of Negro physicians be recognized by the House of Delegates, will it tend to retard the removal of present restrictions, obtaining in some states, militating against free professional relationships between white and Negro physicians;” “If Negro physicians be accorded this special treatment and recognition, will not other racial groups have some cause to apply for similar special recognition;” inasmuch as “there are only 166 Negro physicians licensed to practice in North Carolina... The organizational setup of the American Medical Association would become extremely complicated if recognition were accorded to a second constituent association having a very small membership;” although the resolution states that “the Medical Society of the State of North Carolina, at its annual meeting in May, 1951, voted to approve this request and sponsor the Old North State Medical Society as a constituent of the American medical Association... [The AMA Bureau of Legal Medicine and Legislation could find] no information as to any official action taken by the Medical Society of the State of North Carolina in approval of this request”; and, finally, “the fact that the Old State Medical Society is composed of dentists and pharmacists, as well as physicians, would preclude affiliation with the American Medical Association.” <i>Board of Trustees report is adopted.</i>
1963	The Rhode Island Medical Society proposes that “the Board of Trustees of the American Medical Association be, and hereby is, instructed to take such action as it deems necessary or appropriate to deny the rights and privileges of membership in the American Medical Association to members of any constituent association or component society thereof which denies membership to any qualified physician because of race, religion or place of national origin.”	Reference Committee reports that insofar as “very definite progress has been made in providing opportunities for membership in county and state medical societies” and that “there are a number of Negro members of state medical societies who have not chosen to become members of the American Medical Association,” the Reference Committee recommended that “this resolution be not adopted” and that, instead, “the House reaffirm its position adopted in 1950 and that a copy of the 1950 resolution again be sent to each constituent and component medical society.” <i>Reference Committee report is adopted.</i>

- due to its “controversial” nature.^{21(p171)}
- NMA leaders asked repeatedly for the AMA to join with them in supporting efforts to amend the Hill-Burton Act’s “separate but equal” provision, which allowed for the construction of segregated hospital facilities with federal funds, but the AMA remained silent.^{2,35}

The genesis of this antipathy was multifaceted. In addition to northern physicians’ apparent concerns about alienating southern medical societies and splitting the profession, the democratic nature of policy decision making at the AMA made it difficult to proceed on a policy agenda opposed by the southern voting bloc. In addition, and perhaps of greater importance, civil rights competed with other issues for the AMA’s attention. Specifically, the foremost concern on the AMA’s agenda in this era was combating federal encroachment into health care, such as the 1960s adoption of the Medicaid and Medicare programs, which AMA leaders had long

castigated as “socialized medicine.”³⁶ In 1964, NMA president Kenneth W. Clement (1920-1974) explained why he thought the AMA was not advocating for changes to the Hill-Burton Act: “The [AMA’s] opposition to federal control over hospital[s] is much better known and established than its interest in removing discrimination based on race from admission and staffing policies.”³⁵

In 1963 AMA and NMA representatives met periodically as a “liaison committee” at the AMA’s Chicago headquarters to attempt to avoid direct confrontation over these issues and to develop a common agenda. On August 7 and 12-13, 1963, they convened to discuss the Hill-Burton Act, Medicare, and other issues of concern to the NMA. Following this meeting, AMA President-elect Norman A. Welch (1902-1964) predicted that the AMA would probably advocate for repeal of Hill-Burton’s “separate-but-equal” clause after another liaison committee meeting planned for December 19, 1963.^{21(p175)} But by this time, Cobb, now the NMA president, openly expressed his frustration:

Table 2. AMA Policies and Proposals to Address Racial Discrimination in Constituent Societies (cont)

Date	Policy/Policy Proposal	Response
1964	The Medical Society of the State of New York proposes “That the American Medical Association 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” and that the AMA “use its influence to end discriminatory racial exclusion policies by some county medical societies as contrary to the law of the land and the ethics of our profession.”	The Reference Committee considered these resolutions together and reported “That this House of Delegates of the American Medical Association is unalterably opposed to the denial of membership, privileges and responsibilities in county medical societies and state medical associations to any duly licensed physician because of race, color, religion, ethnic affiliation, or national origin,” and “That this House of Delegates of the American Medical Association calls upon all state medical associations, all component societies, and all individual members of the American Medical Association to exert every effort to end every instance in which such equal rights, privileges, or responsibilities are denied.” <i>Reference Committee report is adopted.</i>
1964	The California Delegation proposes “That this House of Delegates direct the Board of Trustees to formulate, at the earliest possible opportunity, such appropriate 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 further that the AMA Board of Trustees instruct “all appropriate divisions, councils, and committees of the Association” to initiate a study in order to determine the scope and extent of discriminatory practices which affect physicians.	
1964	The State Medical Society of Wisconsin proposes “That the Board of Trustees of the American Medical Association be, and hereby is, instructed to take such action as it deems necessary or appropriate to deny the rights and privileges of membership in the American Medical Association to members of any constituent association or component society thereof which denies membership to any qualified physician because of race, religion, or place of national origin.”	
1965 ²²	The Medical Society of the State of New York proposes “That until such racial exclusion policies [in county medical societies] are ended, the American Medical Association establish acceptable standards and procedures for admitting to direct membership in the American Medical Association those physicians who have thus been denied county medical society membership and thereby are unable to join certain hospital staffs or specialty organizations requiring American Medical Association membership.”	The Reference Committee recommends that in lieu of this resolution the AMA reaffirm its position of 1964. <i>Reference Committee report is adopted.</i>

For seven years we have invited them [the AMA, the American Hospital Association, and others] to sit down with us and solve the problem [of hospital

integration]. The high professional and economic levels of these bodies and the altruistic religious principles according to which they are supposed

Table 2. AMA Policies and Proposals to Address Racial Discrimination in Constituent Societies (cont)

Date	Policy/Policy Proposal	Response
1966 ^{23,24}	Connecticut, California, New Hampshire, and New York, propose that "the <i>Constitution and Bylaws</i> of the American Medical Association be amended to provide in substance that membership in the American Medical Association of any constituent association or component county society shall be revoked if such constituent association or component society shall deny full membership to any individual on the basis of race, creed, or color."	The two resolutions are considered together and a substitute resolution is proposed by the Council on Constitution and Bylaws, that "The [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." <i>Substitute resolution is adopted.</i>
1966	The New York and New Jersey state medical associations propose that the AMA Constitution and Bylaws be changed such that "No applicant for membership shall be barred because of his race, color or creed. A physician whose application for membership in a component medical society has not been acted upon within six months, or whose application has been rejected, shall have the right of appeal to the constituent association of which the component society is a part. If admission to membership is denied by the constituent association, he shall have the right of appeal to the Judicial Council of the American Medical Association."	
1966	The Pennsylvania Delegation proposes "That the American Medical Association, through, the appropriate departments, make inquiry to ascertain whether or not there is any evidence of discrimination in county or state medical societies and report back to the House of Delegates of the American Medical Association."	Reference Committee reports 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 Reference Committee recommends reaffirming the 1964 policy. <i>Reference Committee report is adopted.</i>
1968	Report LL, "Cooperation Between AMA and National Medical Association," is brought by the NMA Liaison Committee and the AMA Board of Trustees, which recommends "(a) That when cases of alleged discrimination are brought to the attention of either the NMA or the AMA, these cases should be reported to the other organization; (b) That each organization request its local constituent medical society to thoroughly investigate the charge and to share these finding with the Joint NMA-AMA Liaison Committee; (c) That the Joint Liaison Committee review these reports to determine (1) the validity of the charge; (2) if further investigation is necessary and, if so, whether the Joint Liaison Committee should conduct further investigations; and (3) whether the AMA Judicial Council should be requested to assume original jurisdiction in the case where appropriate; and that the current AMA policy on non-discrimination in medicine and hospital staff privileges be reaffirmed by the AMA House of Delegates."	Report is adopted.
1968	The Massachusetts Delegation proposes a change to the bylaws so that "any physician whose application for membership in a component and/or constituent association has allegedly been denied unfairly because of color, creed, race, religion, or ethnic origin, may appeal to the [AMA] Judicial Council. The Council shall determine the facts in the case and report the finding to the House of Delegates. If the Council determines that the allegations are indeed true, it shall admonish, censure or, in the event of repeated violations, recommend to the House of Delegates that the state association involved be declared to be no long a constituent member of the American Medical Association."	The Council on Constitution and Bylaws recommends that "although in sympathy with the intent of Resolution 24, [the Council] believes that its provisions for additional enforcement procedures of the AMA's policy opposing racial discrimination are unnecessary." Over the council's objections, the resolution is adopted.

to operate seem to have meant nothing. By their refusal to confer they force action by crisis. And now events have passed beyond them. The initiative offered is no longer theirs to accept.^{21(p174)}

Cobb was proven correct when Congress passed and President Johnson signed into law the Civil Rights Act of 1964. The NMA championed the act,^{21(p172)} while AMA records contain only a single passing mention of it prior to its passage, noting simply that it would be taking up the legislative agenda for Congress in the week of its passage.

Fighting the Oath of Compliance and Medicare

Within the Civil Rights Act, Title VI prohibited discrimination in federally funded programs and mandated the withdrawal of federal funds from any segregated facility.^{37,38} On January 3, 1965, the Department of Health, Education, and Welfare (HEW) created regulations pursuant to Title VI that forbade discriminatory practices previously allowed by Hill-Burton. Hospitals receiving Hill-Burton funds could no longer legally practice racial discrimination in the selection of physicians as interns, residents, and admitting staff, nor could they legally exclude or segregate patients on the basis of race.^{39,40}

Although the AMA remained silent during debates over the Civil Rights Act, it was not always silent regarding its implementation. The original HEW regulations implementing Title VI would have required all recipients of federal funds, including physicians, to sign a statement of compliance, formally forswearing racially discriminatory practices.⁴¹ The AMA strenuously objected to this, and its House of Delegates voted to “oppose actively and forcefully this and any future attempts by HEW or any other federal agency to impose conditions and pledges upon the medical profession.”⁴² The AMA said any oath of compliance with civil rights obligations would be “discriminatory” towards physicians and “degrading,” because physicians already had a code of ethics that forbade discrimination. As Dr Donald Hayes, the chairman of the committee that examined this issue, claimed, physicians “have traditionally treated patients regardless of race, color, creed or national origin.”⁴³ In November 1966 the AMA house reiterated its opinion that

*[t]he medical profession does not support discrimination among patients on the basis of race, color, or national origin, neither is it ready to accept a requirement that it certify its innocence of discrimination as a condition for providing care to the needy.*⁴⁴

The AMA took credit when HEW dropped the requirement, thereby rendering individual physicians’ services less accountable to the civil rights act—and granting physicians a unique status as recipients of federal funds

that persists, and has repercussions, to this day.⁴⁵⁻⁴⁷

In sum, throughout numerous hospital desegregation battles and the passage and implementation of the Civil Rights Act, the AMA tended towards silence, ambivalence, or opposition, while the NMA was a strong advocate. This produced stress. But in other important health policy battles, tensions between the AMA and NMA were further heightened by the fact that the organizations took starkly opposing positions. Most notably, since 1946, the NMA had backed the notion of a National Health Insurance Plan and, in 1962, its House of Delegates endorsed Medicare.⁴⁸ The AMA, viewing Medicare as “socialized medicine,” saw it as a threat to the medical profession and to high-quality health care and was solidly opposed. Instead of Medicare, the AMA backed the 1960 Kerr-Mills Law, which provided federal matching grants to support state-administered health care programs for the elderly.⁴⁹ The NMA countered that Kerr-Mills was inadequate, its results “disappointing,” and that funding health care “through social security [ie, Medicare] offered the greatest opportunity and probability that the health needs of the aged would be fully met.”⁵⁰ These conflicting organizational policy positions seem to have reflected a national racial divide over Medicare. The AMA’s opposition to Medicare reflected the sentiment of the great majority of white physicians at the time (for example, only 38% of New York physicians supported Medicare’s passage in 1965⁵¹) and NMA leaders acknowledged that their strong support for Medicare made the NMA “a dissenter from the dominant organization in American medicine,”^{21(p173)}

Increasing Confrontation Over Exclusion from Society Memberships

Although the AMA passed several resolutions between 1939 and 1965 stating that it was “unalterably opposed” to discrimination (Table 2), most of the AMA’s southern county societies still denied membership to African American physicians when the Civil Rights Act passed.^{21(pp132-137,175)} When the NMA and others complained that the AMA was failing to act on its stated principles, AMA leaders repeatedly responded that they disliked racial discrimination but had no authority to dictate membership criteria to the constituent societies, given the existing AMA constitution and bylaws.

Throughout this time, however, some physicians directly questioned the implication that the AMA was powerless over its constituents or its constitution. In 1952 Pediatrician Martha Mendell (1902-2001), a member of the Physicians Forum (an activist medical organization in New York) noted:

The continued exclusion of Negro physicians by southern medical societies is not just a national, but an international disgrace. The claim of the AMA that it is powerless to correct this practice

because of the “autonomy” of its component societies is an evasion of its responsibility. Surely, if the southern medical societies decided to admit chiropractors to membership the AMA would quickly find the means of re-defining this autonomy.^{52(p305)}

At the AMA’s 1964 annual meeting, Arthur H. Coleman (1920-2002) (Figure 4), a black physician from San Francisco and a legal consultant to the NMA,⁵³ likened condemning discrimination but doing nothing to halt it to:

*[a] man who is standing on the shoreline watching a fellow-man floundering in the sea and proclaiming to the world and to his God that he does not believe in drowning. This alone does nothing for the man in the sea....Their conscience may be eased so that they can sleep at night to ‘take a stand against discrimination,’ but, it takes a concerted effort of positive action to rescue those caught in the sea of discrimination.*⁵⁴

To increase pressure on the AMA, the NMA and others mounted a series of direct confrontations. On June 12, 1963, the MCHR—a biracial, national organization composed of primarily liberal, white physicians—and other prominent white and black organizations sent 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.”^{21(p162)} Finding the AMA’s response to their appeal “totally inadequate,”^{21(p162)} NMA and MCHR members and other health workers, led by future NMA president John L.S. Holloman Jr (1919-2002), picketed the AMA’s 1963 meeting.⁵⁵ The AMA board’s chairman, Percy E. Hopkins (1892-1967), responded that the picketing accomplished nothing except “to obscure the achievements in medical science being reported at the meeting.”^{21(p163)}

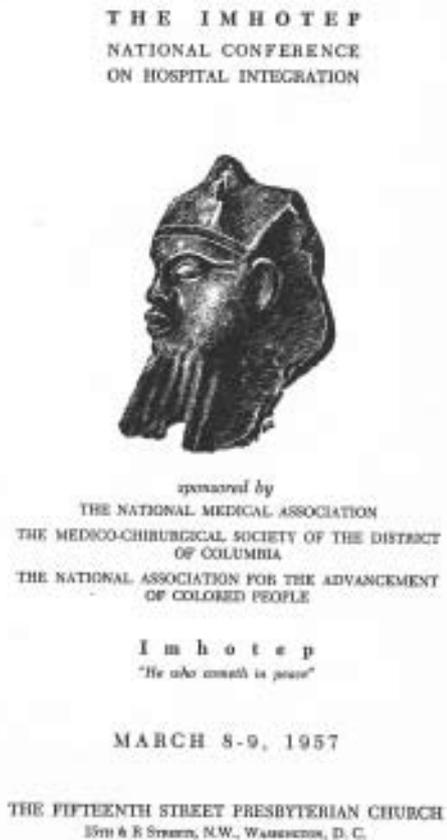
Figure 2. William Montague Cobb (1904-1990), Editor of the *Journal of the National Medical Association* (1949-1977) and President of the National Medical Association (1964-1965)^{11(p143)}



The MCHR resumed its picket at the AMA’s Chicago offices 2 weeks after the 1963 meeting. The 1965 AMA meeting in New York City was protested by about 200 NMA-led picketers, urging the AMA to “Integrate All County and State Medical Societies!” and “End Discrimination in Medicine Now!”^{21(pp163-164)} The NMA and MCHR also picketed the AMA’s 1966 scientific meeting in Chicago (Figure 5).

Following passage of the Civil Rights Act in 1964 and Medicare in 1965, segregation within hospitals became illegal.^{46,55} Since many local and state societies had also taken on quasi-governmental functions, such as interactions with licensure boards, it is possible that legal challenges to segregation within these societies would have succeeded at this time. But in 1966 the AMA house finally voted to amend the AMA constitution and bylaws, giving the Judicial Council (now the Council on

Figure 3. First Imhotep National Conference on Hospital Integration



The first Imhotep conference was held at the Fifteenth Street Presbyterian Church, Washington, DC, March 8-9, 1957. Among the 175 registrants were representatives from 16 societies of the NMA, 26 chapters of the NAACP, four branches of the National Urban League, and 32 organizations with an interest in hospital work, including the AMA, the American Hospital Association, the American Nurses Association, the National Health Council, and the United States Public Health Service.^{11(pp143-144)}

Ethical and Judicial Affairs, CEJA) the authority to investigate allegations of discrimination in state societies.^{44(pp130,208-209)} In 1968, over the objections of the AMA's Council on Constitution and Bylaws, the house voted to adopt a Massachusetts proposal that granted CEJA the power to expel constituent societies for racial discrimination in membership policies.^{56(pp137,207)} By this time, however, there appear to have been no remaining openly discriminatory county or state societies; CEJA's authority to investigate and sanction racial discrimination has never been exercised.

DISCUSSION

Although integration and acceptance were repeatedly expressed as ethical ideals for the AMA, its policy decisions between 1910 and 1968 nearly always allowed segregation and exclusion to prevail. Its words and actions sent the message that racial segregation was wrong but tolerable. The organization repeatedly voted to condemn racism but to accept bigotry and Jim Crow segregation, and its leaders refused—despite numerous opportunities—to defend the civil rights of African American physicians. It was not until after the passage of the Civil Rights Act—and its linkage to Medicare payments, which ended legalized segregation in American hospitals—that the AMA demanded desegregation among its constituent societies.

This results of this legacy of exclusion remain with us. First, the impact of professional exclusion on African American patients is not the focus of this paper, but it seems likely that patients were harmed by generations of African American physicians being excluded from the medical mainstream, with the training, resources, and other opportunities it held. Similarly, it might be impossible to disentangle the effects of this professional discrimination from the effects of pervasive segregation and racism throughout health care, education, the law, and other aspects of American society, since health and

well-being are affected by much more than doctors.⁵⁷ Without doubt, however, the negative health effects attributable to professional discrimination in medicine have been high and they are ongoing. Indeed, we consider today's persistent racial and ethnic health disparities to be part of the legacy attending to this history.

Many physicians follow relatives into medicine. As a result of this legacy of exclusion, generations of African Americans were not merely denied opportunities for basic and specialty training in medicine; they were largely denied familial examples as well. It is partly for these reasons that, in 2005, African Americans made up 12.3% of the US population⁵⁸ but just 2.2% of all physicians and medical students.⁵⁹ This is fewer than the 2.5% of physicians who were African American when Abraham Flexner wrote his report on medical education in 1910.

Meanwhile, despite targeted outreach efforts for more than 20 years, African Americans in 2006 made up only 1.8% of AMA members, 1.9% of the AMA House of Delegates, 5.0% of AMA councils and the leadership of AMA sections and Special Groups, and 0.0% of the AMA's 21-member Board of Trustees.⁶⁰ Such underrepresentation risks narrowing the scope of medical discussions and hinders the ability of the AMA to serve as a legitimate voice of American medicine. By most definitions, "professions" require the existence of unified professional associations to set standards, self-regulate, and advocate for their members.⁶¹ A lack of diversity within the AMA, splintering the so-called "house of medicine," threatens the credibility, and perhaps the existence, of the AMA and American medicine as a profession.

While the legacy of this history is powerful—for society, for the profession, and for the AMA—a number of notable events since 1968 illustrate the continuing evolution of the relationship between the AMA and African American physicians.⁶² The AMA asserted the need

Figure 4. Arthur H. Coleman (1920-), Physician From San Francisco and Legal Consultant to the National Medical Association.^{11(pp180)}



Figure 5. Biracial Coalitions Picket American Medical Association, 1965-1966



Members of the National Medical Association and Medical Committee for Human Rights and other health workers picket American Medical Association annual meetings in 1965. John L. S. Holloman, Jr. (1919-2002) (above left),^{11(pp164-165)}

to increase the number of African American physicians in 1968—a policy position that has been reinforced many times since.⁶³⁻⁶⁵ In 1989, CEJA wrote a report on *Black-White Disparities in Health Care*, one of the first major national reports on health disparities.⁶⁶⁻⁶⁷ The AMA created its Minority Affairs Consortium in 1992,⁶⁸ which gained a voting seat in the AMA house in 2006.⁶⁹ The first African American AMA President, Lonnie Bristow (1930-), was elected in 1994 and, in 1995, Regina Benjamin (1956-) became the first African American woman to be elected to the AMA board.⁷⁰ The NMA gained a voting seat in the AMA house in 1996.⁷¹ In 2004 the AMA, NMA, and National Hispanic Medical Association joined to form the Commission to End Health Care Disparities, a collaborative group that now includes more than 70 state and specialty societies.⁷² For the last several years, the AMA president has addressed the annual meeting of the NMA and, in several instances, has acknowledged the historical exclusion of African Americans from the AMA.

Most recently, AMA support for this independent exploration of its history is itself a part of this evolving story. And, following the publication in *JAMA* of a summary of our findings in July 2008,² Ronald Davis and J. James Rohack, immediate past president and president-elect of the AMA, respectively, spoke to the NMA House of Delegates to issue a formal public apology on behalf of the AMA for the organization's history of segregation and discrimination.⁷³ Davis noted that an apology is only the beginning of what needs to be done to remedy the effects of this history and he quoted from an editorial in the *New York Sun*, published in response to the AMA's apology. "There are those who say that apologies can't change the past, and they have a point. The hope is that they will change the future."⁷⁴

As AMA and NMA leaders continue to work together to help move the medical profession forward, our hope is that they will do so in clear recognition of the past and its effects, but also in awareness that the history of African American physicians and organized medicine is still being written.

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The Writing Group on the History of African Americans and the Medical Profession includes Robert Baker, PhD, The Union Graduate College-Mount Sinai School of Medicine Bioethics Program, and Department of Philosophy, Union College; Janice Blanchard, MD, George Washington University School of Medicine, Department of Emergency Medicine; L. Ebony Boulware, MD, MPH, Johns Hopkins Medical Institutions, Welch Center for Prevention, Epidemiology and Clinical Research; Clarence Braddock, MD, MPH, Stanford Center for Biomedical Ethics; Giselle Corbie-Smith, MD, MSc, Department of Social Medicine, University of North Carolina at Chapel Hill; LaVera Crawley, MD, MPH, Stanford University Center for Biomedical Ethics; Eddie Hoover, MD, editor, *Journal of the National Medical Association*; Elizabeth Jacobs, MD, MPP, Cook County Hospital and Rush Medical College; Thomas A. LaVeist, PhD, Johns Hopkins Bloomberg School of Public Health, Department of Health Policy and Management; Randall Maxey, MD, PhD, past president, NMA; Charles Mills, PhD, University of Illinois at Chicago; Kathryn L. Moseley, MD, University of Michigan Medical School; Todd L. Savitt, PhD, Department of Medical Humanities, Brody School of Medicine, East Carolina University; Harriet A. Washington, visiting scholar, DePaul University College of Law; David R. Williams, PhD, Institute for Social Research, University of Michigan.

REFERENCES

1. Davis RM. Achieving racial harmony for the benefit of patients and communities: Contrition, reconciliation and collaboration. *JAMA*. 2008; 300(3):323-5.
2. Baker RB, Washington HA, Olakanmi O, et al. African American physicians and organized medicine, 1846-1968: Origins of a racial divide. *JAMA*. 2008; 300(3):306-314.
3. Savitt T. Abraham Flexner and the black medical schools. *J Natl Med Assoc*. 2006;98:1415-1424.

4. Baker R, Washington HA, Olakanmi O, et al. Creating a segregated medical profession: African American physicians and organized medicine, ~1847-1910. *J Natl Med Assoc.* (under review).
5. Past and Future Conventions. National Medical Association web site. http://nmanet.org/index.php/ConvJspargo/past_future. Accessed October 30, 2008.
6. Minutes of the business meeting of the board of trustees of the American Medical Association. May 23, 1931:313-314. Located at: American Medical Association Archives, Chicago, IL.
7. *American Medical Directory*. 1st ed. Chicago, IL: American Medical Association Press; 1906.
8. Minutes of the business meeting of the board of trustees of the American Medical Association. September 15-17, 1938. Located at: American Medical Association Archives, Chicago, IL.
9. *New York Times*. August 16, 1939. "Mayor asked equality for negro doctors. Says at convention that germs don't obey Jim Crow laws." Available online at: <http://select.nytimes.com/mem/archive/pdf?res=FA0D12F93954107A93C4A81783D85F4D8385F9> (subscription required). Accessed October 30, 2008.
10. Minutes of the business meeting of the board of trustees of the American Medical Association. September 22-23, 1939:89-92. Located at: American Medical Association Archives, Chicago, IL.
11. Woodward CV. *The Strange Career of Jim Crow*. 2nd revised ed. New York, NY: Oxford University Press; 1966.
12. Gamble VM. *Making a Place for Ourselves: The Black Hospital Movement, 1920-1945*. New York, NY: Oxford University Press; 1995.
13. Byrd WM, Clayton LA. *An American Health Dilemma: Race, Medicine, and Health Care in the United States, 1900-2000*. New York, NY: Routledge; 2000.
14. Hyde DR, Wolff P, Gross A, Hoffman EL. The American Medical Association: power, purpose, and politics in organized medicine. *Yale Law J*. 1954;63(7):937-1022.
15. Hall O. The stages of a medical career. *Am J Sociol*. 1948;53(5):327-336.
16. Buckler H. Daniel Hale Williams: Negro Surgeon. New York, NY: Pitman Publishing Corp; 1954.
17. William Harry Barnes, MD. American Academy of Otolaryngology – Head and Neck Surgery web site. http://entspecialists.org/museum/exhibits/africanamerican_barnes.cfm. Accessed October 30, 2008.
18. Proceedings of the house of delegates of the American Medical Association; May 15-19, 1939; St. Louis, MO. http://www.nmt.com/ama_ndls. Accessed January 28, 2008.
19. Proceedings of the house of delegates of the American Medical Association; June 12-16, 1944; Chicago, IL. http://www.nmt.com/ama_ndls. Accessed January 28, 2008.
20. Marable M. *Race, Reform, and Rebellion: The Second Reconstruction in Black America, 1945-1990*. 2nd revised ed. Jackson, MS: University Press of Mississippi; 1991:14-15.
21. Morais H. *The History of the Negro in Medicine*. 1st ed. New York, NY: Association for the Study of Negro Life and History and Publishers Co Inc; 1967.
22. Proceedings of the house of delegates of the American Medical Association; December 6-9, 1949; Washington, DC:39. http://www.nmt.com/ama_ndls. Accessed January 28, 2008.
23. Proceedings of the house of delegates of the American Medical Association; June 26-30, 1950; San Francisco, CA:67. http://www.nmt.com/ama_ndls. Accessed January 28, 2008.
24. Reitzes D. *Negroes and Medicine*. Cambridge, MA: Harvard University Press; 1958.
25. Raup RM, Williams EA. Negro students in medical schools in the United States. *J Med Ed*. 1964; 39:444-450.
26. Proceedings of the house of delegates of the American Medical Association; December 2-5, 1952; Denver, CO. http://www.nmt.com/ama_ndls. Accessed January 28, 2008. pp.11-12.
27. Proceedings of the house of delegates of the American Medical Association; December 2-4, 1963; Portland, OR. http://www.nmt.com/ama_ndls. Accessed January 28, 2008. pp.178-9.
28. Richard MP. The Negro physician: Babbitt or revolutionary? *J Health and Soc Behav*. 1969; 10(4):265-274.
29. Stevens R. *American Medicine and the Public Interest: A History of Specialization*. Berkeley, CA: University of California Press; 1971.
30. Brickman JP. Minority politics in the house of medicine: the Physicians Forum and the New York County Medical Society, 1938-1965. *J Public Health Policy*. 1999;20(3):282-309.
31. Kessel RA. The A.M.A. and the supply of physicians. *Law Contemp Prob, Health Care: Part 1*. Spring, 1970; 35(2):267-283.
32. Reynolds PP. Professional and hospital discrimination and the US court of appeals fourth circuit, 1956-1967. *Am J Public Health*. 2004;94(5):710-720.
33. Reynolds PP. Hospitals and civil rights, 1945-1963: the case of Simkins v Moses H Cone Memorial Hospital. *Ann Intern Med*. 1997;126(11):898-906.
34. Walt AJ, Wilson RF, Rosenberg IK, et al. The anatomy of a civil disturbance. *JAMA*. 1967;202(5):394-397.
35. Clement statement on AMA proposed Hill-Burton amendment. *J Natl Med Assoc*. 1964;56(3):287.
36. Burrow JG. *AMA: Voice of American medicine*. Baltimore, MD: Johns Hopkins Press; 1963.
37. Civil Rights Act of 1964, 42 USC §2000d et seq. (1964). Seattle University Web site. <http://www.seattleu.edu/artsci/history/us1945/docs/cr64.htm>. Accessed September 16, 2007.
38. Stewart WH. Civil rights and Medicare. *JAMA*. 1966;196(11):175.
39. Implementation of the civil rights act in medical areas: federal rules and regulations. *J Natl Med Assoc*. 1965;57(2):157-162.
40. National conference on title VI—Civil Rights Act of 1964. *J Natl Med Assoc*. 1965;57(2):163-165.
41. Law Department of the American Medical Association. Analysis of Civil Rights Act in relation to the medical profession. April 12, 1966:4. Located at: American Medical Association Archives.
42. Proceedings of the house of delegates of the American Medical Association, special convention; October 2-3, 1965; Chicago, IL. http://www.nmt.com/ama_ndls. Accessed November 25, 2008. p.9.
43. Proceedings of the house of delegates of the American Medical Association; June 26-30, 1966; Chicago, IL. http://www.nmt.com/ama_ndls. Accessed November 25, 2008. p.157.
44. Proceedings of the house of delegates of the American Medical Association; November 28-30, 1966; Las Vegas, NV. http://www.nmt.com/ama_ndls. Accessed November 25, 2008. p.69.
45. Smith DB. Healthcare's hidden civil rights legacy. *St Louis Univ Law J*. 2003;48(1):37-60.
46. Reynolds PP. The federal government's use of title VI and Medicare to racially integrate hospitals in the United States, 1963 through 1967. *Am J Public Health*. 1997;87(11):1850-1858.
47. Rosenbaum S, Markus A, Darnell J. US civil rights policy and access to health care by minority Americans: implications for a changing health care system. *Med Care Res Rev*. 2000;57(suppl 1):236-259.
48. Editorial. The president and the nation's health. *J Natl Med Assoc*. 1965;57(2):156.
49. Campion FD. The expansion of access: Medicare and Medicaid. In: *The AMA and US Health Policy Since 1940*. Chicago, IL: Chicago Review Press; 1984:253-284.
50. Clement KW. National Medical Association testimony in behalf of HR 3920, the King-Anderson bill, before the Committee on Way and Means, United States House of Representatives, January 22, 1964. *J Natl Med Assoc*. 1964;56(2):213-220.
51. Colombotos J. Physicians and Medicare: A before-after study of the effects of legislation on attitudes. *Am Sociol Rev*. 1969;34(3):318-334.
52. Mendell M. New York County Medical Society election makes news. *Physicians Forum Bulletin*. March 1952:17-18. In: Brickman JP. Minority politics in the house of medicine: the Physicians Forum and the New York County Medical Society, 1938-1965. *J Public Health Policy*. 1999;20(3):282-309.
53. Howard K. Arthur H Coleman. *BMJ*. 2003;326(7384):339.
54. Statement by Arthur H. Coleman, MD, LLB, before the Amendments to Constitution and By-laws Reference Committee on Resolutions, at the AMA meeting in San Francisco, on June 23, 1964. *J Natl Med Assoc*. 1965;57(1):61.

55. Smith DB. The racial integration of medical and nursing associations in the United States. *Hosp Health Serv Adm.* 1992;37(3):387-401.
56. Proceedings of the house of delegates of the American Medical Association; December 1-4, 1968; Miami Beach, FL. http://www.nmt.com/ama_ndls. Accessed January 28, 2008.
57. Beardley EH. *A History of Neglect: Health Care for Blacks and Mill Workers in the 20th Century South*. Knoxville, TN; University of Tennessee Press; 1990.
58. Annual estimates of the population by sex, race, and Hispanic or Latino origin for the United States: April 1, 2000 to July 1, 2005. United States Census Bureau Web site. <http://www.census.gov/popest/national/asrh/NC-EST2005/NC-EST2005-03.xls>. Accessed September 20, 2007.
59. Minorities in medical education: facts and figures 2005. Association of American Medical Colleges Web site. <http://www.im.org/AAIM/PublicPolicy/Docs/AAMCMIM05.pdf>. Accessed September 16, 2007.
60. Report of the Council on Long Range Planning and Development. American Medical Association Web site. <http://www.ama-assn.org/ama1/pub/upload/mm/409/2007demographicrepor.pdf>. Accessed November 25, 2008.
61. Wynia MK. The short history and tenuous future of medical professionalism: The erosion of medicine's social contract. *Perspect Biol Med.* Autumn 2008. 51(4):565-578.
62. Race and the AMA: a chronology. American Medical Association Web site. <http://www.ama-assn.org/ama/pub/category/print/9496.html>. Accessed November 25, 2008.
63. Proceedings of the house of delegates of the American Medical Association; June 16-20, 1968; San Francisco, CA. http://www.nmt.com/ama_ndls. Accessed January 28, 2008.p96-9
64. Proceedings of the house of delegates of the American Medical Association; June 15-19, 1975; Atlantic City, NJ:415,460. http://www.nmt.com/ama_ndls. Accessed January 28, 2008.
65. Proceedings of the house of delegates of the American Medical Association; June 18-22, 1978; St. Louis, MO:213-214,373. http://www.nmt.com/ama_ndls. Accessed January 28, 2008.
66. Proceedings of the house of delegates of the American Medical Association; June 18-22, 1989; Chicago, IL:384. http://www.nmt.com/ama_ndls. Accessed January 28, 2008.
67. Council on Ethical and Judicial Affairs of the American Medical Association. Black-White Disparities in Health Care. *JAMA.* 1990; 263: 2344-2346
68. Proceedings of the house of delegates of the American Medical Association; June 21-25, 1992; Chicago, IL:401. http://www.nmt.com/ama_ndls. Accessed January 28, 2008.
69. Minority Affairs Consortium membership. American Medical Association Web site. <http://www.ama-assn.org/ama/pub/category/9167.html>. Accessed August 30, 2007.
70. Proceedings of the house of delegates of the American Medical Association; June 12-16, 1994; Chicago, IL:442. http://www.nmt.com/ama_ndls. Accessed January 28, 2008.
71. Proceedings of the house of delegates of the American Medical Association; June 23-27, 1996; Chicago, IL:62-63. http://www.nmt.com/ama_ndls. Accessed January 28, 2008.
72. Commission to End Health Care Disparities. American Medical Association Web site. <http://www.ama-assn.org/ama/pub/category/12809.html>. Accessed August 30, 2007.
73. Davis RM. The American Medical Association and the National Medical Association: past, present and future. <http://www.ama-assn.org/ama/pub/category/18820.html> Accessed November 25, 2008.
74. Editorial. The AMA Apology New York Sun. July 23, 2008. <http://www.amaapology.com/news8.html> . Accessed November 25, 2008. ■