

## Integrative Assignment

Name: Devon Atchison

Discipline: History

**Public Issue:** Medical ethics, race

And/or

**Student Need:** Critical thinking, good citizenship

### 1. Describe the Assignment.

--See Attached Assignment.

### 2. Describe the learning outcomes from each course that are embedded in the assignment.

--History 112 SLO #1: Analyze and synthesize Modern American historical sources in response to an historical thesis or question.

### 3. Describe what students will do in the context of each course to prepare for the assignment and complete the assignment.

-- Students will individually read *The Immortal Life of Henrietta Lacks* and participate in an in-class discussion of the book before the Research Paper is started.

-- Students will receive the Research Paper topics when they begin reading the book, but aside from note-taking and brainstorming, will not begin work on the paper until after the book has been completed and the discussion of the book has been held. Students will then read the two accompanying essays and begin browsing the Primary Source Sets to find appropriate evidence to prove the argument.

### 4. What resources will you use to support the development of the assignment (essays, and/or chapters from your text, newspapers, magazines, community resources, etc.)?

-- Students will read the two accompanying essays and begin browsing the Primary Source Sets (including one Set based on their course Primary Source Reader) to find appropriate evidence to prove the argument.

### 5. How will students monitor their learning? What activities will you require for follow-up?

Because we are having a pre-writing in-class discussion of the book, students will have an opportunity to grapple with parts of the book that were difficult to comprehend. I require that students turn in Rough Drafts of the paper, so students will have clear direction as they prepare the Final Draft of the essay, and I provide feedback on the Final Draft via a rubric.

## HISTORY 112 RESEARCH PAPER

You will be using the following texts in your paper:

- a) Rebecca Skloot's *The Immortal Life of Henrietta Lacks*
- b) Louise Cavagnaro and Anne Bennett Swingle's essay, "The Way We Were" (pages 2-4 of this handout)
- c) The NPR transcript of an interview with Harriet Washington on her book *Medical Apartheid* (pages 5-9 of this handout)
- d) **At least one primary source from one of the following Primary Source Sets:**
  1. PRIMARY SOURCES SET #1, **JIM CROW**: Click [here](#) for Oral Histories about Jim Crow from the PBS special, "The Rise and Fall of Jim Crow"
  2. PRIMARY SOURCES SET #2, **BROWN v. BOARD**: Click [here](#) for court documents, articles and cartoons about segregation, integration and, more specifically, the landmark 1954 court decision of *Brown v. Board of Education*.
  3. PRIMARY SOURCES SET #3, **CHAPTER 2 OF FRAZIER**: You can use any of the Documents from the "School Desegregation" or "Civil Rights" sections of Chapter 2 in Thomas Frazier's *The Many Sides of America: 1945 to the Present*.

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You should select one of the two essay prompts/arguments for your paper

1. The American historical record clearly demonstrates centuries of discrimination against blacks via segregation, among other means. Using *The Immortal Life*, "The Way We Were" and the transcript on "Medical Apartheid," as well as at least one primary source from the list above, prove the argument that African Americans had distinctly different, and thus substandard, experiences with medical care because of segregation and notions of black inferiority. In the course of your essay, you should be sure to draw connections between the segregation blacks experienced in medical care with segregation outside of medical care.

2. Despite generations of racial strife in Maryland, Johns Hopkins University's hospital was, from the outset, a hospital designed to function without regard to "sex, age, or color." Using *The Immortal Life*, "The Way We Were," and the transcript on "Medical Apartheid," as well as at least one primary source from the list above, prove the argument that although African Americans were subjected to what author Harriet Washington calls "medical apartheid" in medical care (substandard and long-segregated health care for blacks), Johns Hopkins University's hospital provided Henrietta Lacks comparable treatment—both as a live patient and a novel and scientifically-important cell line—to any other patient.

# The Way We Were

*In the mid-20th century, segregation prevailed across America. A retired administrator recalls what those years were like at Hopkins Hospital.*

Those who saw the HBO film, “Something the Lord Made,” and the PBS documentary, “Partners of the Heart,” will not soon forget the racial barriers faced by Vivien Thomas when he arrived at Hopkins in 1941. The talented surgical technician was confronted with separate rest rooms and dining facilities, discriminatory personnel policies and overt prejudice. Now, a retired administrator who worked at the Hospital from 1953 until 1985 and who played an active role in integrating its patient facilities, has



**In the mid-1950s, Louise Cavagnaro wanted to integrate the private services. She began with Marburg. She issued no public announcements. She just did it.**

detailed even more precisely the extent to which racial segregation prevailed at The Johns Hopkins Hospital and School of Medicine—and how it was eliminated.

When Louise Cavagnaro joined Hopkins, Thomas was already working in the Department of Surgery research laboratory. Because hiring practices were discriminatory, most other African Americans worked in housekeeping or dietary. Some were orderlies; a few were technicians in the operating rooms. Only one was on the full-time faculty. None were on the house staff; none were students in the medical school; and in ways that seem inconceivable today, many facilities were separate—some for “colored,” others for “white.”

This was in no way by design or the result of any articulated institutional policy. It was, rather, a reflection of the social mores of time and place. Baltimore was then very much of a southern city. Its schools, neighborhoods and public facilities were segregated.

Cavagnaro began documenting the practice at JHH in 1989. Her sources were former chief residents, longtime employees, two former Hospital presidents, Russell Nelson and Robert Heyssel; the late A. M. “Mac” Harvey, a former director of the Department of Medicine; and Richard Ross, dean emeritus of the medical faculty. Following are excerpts:

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Johns Hopkins, who came from a family who freed their slaves before the Civil War, said in his letter to his trustees that the Hospital “shall admit the indigent poor—without regard to sex, age, or color ...” Indeed, when the Hospital opened in 1889, the second patient admitted was African American—the first of many. At the end of the first full year of operation, 13.6 percent of patients at Hopkins were listed as “colored.” By 1900, it was 20.7 percent.

At the time, many other hospitals in Baltimore did not admit African Americans.

From the beginning, physicians at Hopkins accorded all patients, regardless of color, the same quality of care and respect. The earliest house staff manual (about 1950-51) notes the policy of addressing all adult patients as Mr., Mrs. or Miss, or by their special title, such as Dr. or Rev. A first name was to be used only when the patient indicated that was his or her preference.

Some public facilities were segregated; some were not. The entrances to the Hospital were open to all (although many blacks assumed the Broadway entrance was off-limits). The emergency room was never segregated, nor were the outpatient facilities (although some clinics had “colored” and “white” days). There were “colored” and “white” waiting rooms outside the general operating rooms on the bridge connecting the Carnegie and Halsted buildings. Public bathrooms were segregated and so were drinking fountains. One little girl, as the story goes, came back to her mother in tears after drinking from the fountain labeled “colored.” She was disappointed to discover that the water, in fact, was not colored at all.

Facilities for patients also were segregated. In March 1894, a two-story “colored ward” opened on Wolfe Street south of the pathology building near where Meyer stands today. In 1916, the hospital superintendent noted in his annual report that “provision for the reception of bodies of those who die in the hospital was deemed not satisfactory.” Two cement, refrigerated rooms were constructed in the Pathology Building—one for white patients, one for “colored.” These separate morgue facilities were retained until 1960.

Patients stayed in either private rooms, semi-private rooms, or on open wards. Some units were never segregated (e.g. the Harriet Lane Home, which opened for children in 1912); others were. The four wards in Osler, for example, were divided into two for “colored” (Osler 2 and 3) and two for white (Osler 4 and 6). Former chief residents recalled that when the units were crowded, blacks were occasionally admitted to empty beds in a white ward. Up until the late 1950s, black patients requesting private or semi-private rooms were not given reservations but placed on a “call list” and admitted to designated rooms.

In the blood bank, recalled Richard Ross, the former dean who arrived in 1947, the shelves were labeled “white blood” and “colored blood.” All the bottles were labeled “colored” or “white.” “Colored” blood was never given to white patients. But in an emergency, white blood was given to black patients.

One employee who began working at the blood bank in 1950 remembered a large blackboard, half of which was painted white and half black, on which the donors’ names were listed in the appropriate space. Black donors were drawn in a separate room from white donors. The employee recalled that blood shipped into Hopkins was not identified by race—except for blood that came from Alabama.

The first black patient was seen in a private outpatient clinic in 1946. The patient’s appointment had been made by letter; no one was aware of his race. Upon discovering the situation, internist James Bordley called Mac Harvey, new director of Medicine, for advice. Harvey told him to see the patient as he would any other.

Little by little, beginning really in the early 1950s, integration took place. Marburg was the first of the inpatient facilities. There were no general announcements or proclamations. In 1956, the admitting office was instructed by the administrator of the private services to gradually implement the change. Three years later, Alfred Blalock, chairman of Surgery and mentor to Vivien Thomas, approved the full integration of the surgical ward services. The Osler nursing units were integrated around 1960. By 1964, only one inpatient service had yet to be integrated: Psychiatry.

The Psychiatric Outpatient Clinic had always provided care to blacks. Those who required inpatient care were referred to a state hospital. The state facilities were segregated. In fact, the state had separate institutions for blacks. Hopkins’ Department of Psychiatry did not accept African-American inpatients in Phipps until around 1968.

The department, however, could lay claim to having the first black physician on the full-time faculty. Earl Nash, a black research scientist in psychotherapy with a Ph.D. from New York University, was appointed to the psychiatry faculty in 1951. He served until his death in 1965.

—*Louise Cavagnaro, with Anne Bennett Swingle*

*A History of Segregation and Desegregation at The Johns Hopkins Medical Institutions*, by Louise Cavagnaro, is on file at the Alan Mason Chesney Medical Archives, 2024 E. Monument St., 410-955-3043      410-955-3043 .

# Transcript of: 'Medical Apartheid' Tracks History of Abuses

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Heard on News & Notes

January 29, 2007 - TONY COX, host:

This is NEWS & NOTES. I'm Tony Cox in for Farai Chideya, who is on vacation.

The medical exploitation of African-Americans has caused mistrust among patients and the medical industry. The most noted case is the Tuskegee experiment of the 1930s. Three hundred ninety nine black men in late stages of syphilis were never told they had the disease. Then, when they were treated by doctors, they had no intention of curing them. This history of involuntary medical experimentation has created a complex relationship between black patients and non-black medical providers.

NPR's Farai Chideya recently talked to Harriet Washington, bioethicist and author of "Medical Apartheid: The Dark History of Medical Experimentation on Black Americans From Colonial Times to the Present." Washington began by explaining the incident that prompted Fannie Lou Hamer to become a civil rights activist.

Ms. HARRIET WASHINGTON (Author, "Medical Apartheid"): Essentially what happened was she had undergone what she was told was an operation to remove what she described as a knot in her stomach. I believed it was probably a benign uterine fibroid, a very common condition among African-American women.

And not until she was back at the plantation where she worked and lived did stories began circulating. Apparently the owner's wife was a cousin of the surgeon who performed the operation. And she knew, although Fannie Lou Hamer did not, that Fannie Lou Hamer's uterus had been removed, rendering her sterile.

This was a very common practice. It was non-consensual. And gynecological surgeons often rendered black women sterile without their knowledge while they were giving birth or undergoing other sorts of medical procedures.

And Fannie Lou Hamer, who always spoke of wanting to have a family, was devastated but also angered by this. And this is what inspired her to, you know, investigate political action as a means of seizing power. She tried to register to vote, was thrown off the

plantation, and the rest as they say is history. She went on to become one of the most important civil rights leaders and symbols of the era.

CHIDEYA: Why did doctors go around sterilizing black women, and how common was it?

Ms. WASHINGTON: Well, it's not a, you know, not a simple question at all. It's actually a very key question. It's very interesting because up until the abolition of slavery, black fertility was prized. It was very important for black women to breed more children who were more slaves and therefore a very important source of wealth for owners.

After slavery was abolished, these children are no longer valued. And the tenet for scientific racism which medical science had used to justify and excuse many abusive practices and abuse of research practices were then expanded. Black people were sterilized at much higher rates than white people, and they were sterilized because they were posited as being both biologically and intellectually unfit parents.

CHIDEYA: This is one specific area of what you call medical apartheid. What is medical apartheid?

Ms. WASHINGTON: Medical apartheid has both commonly been used to refer to the race-driven, very wide disparities in access to health care, quality of health care and protection of human rights. All these racial disparities have led to such a wide gulf, a gulf that's really riven our nation to the point where, 10 years ago, the health of Harlem men more closely resembles Bangladeshi's than their Manhattan neighbors. And this is the picture throughout entire country. Black people are dying in droves of detectable, preventable, curable diseases.

This huge disparity has its roots in unexplored history, which is promulgated at the beginning of slavery to justify enslavement. And medical abuse of blacks still exists today. And a lot of these racist beliefs, which are not scientifically supported but have been embraced by scientists, have driven the wide gulf in health care.

CHIDEYA: One of the historical incidents that provoked this disconnect between African-Americans and the medical establishment was the Tuskegee experiment. Tell us about what was perpetrated.

Ms. WASHINGTON: The Tuskegee syphilis experiment, which is properly called the Public Health Service Study of Syphilis in Untreated Negro Males, is the most iconic symbol of abuse, of racialized medical abuse in research. It ran between roughly 1932 and 1973.

In the late '20s, Julius Rosenwald, who was the owner of Sears, Roebuck and Company, and Booker T. Washington decided to embark on a series of initiatives, in part to eradicate infectious diseases such as syphilis from the denizens of Macon

County, where Tuskegee University was located. But Rosenwald lost his money in the stock market crash. And as a result, the Public Health Service stepped in. But the Public Health Service physicians never shared their goal of black self-sufficiency or black initiative to address health.

The Public Health Service had a very different agenda. They simply wanted to study the progression of syphilis in black men. And they not only wanted to observe these men without treatment, but they also were hoping to validate their belief in a racially dimorphic difference of syphilis in blacks and whites.

Again, the tenets of scientific racism held that black people were less intelligent with underdeveloped nervous systems, however, were very strong physically. And the PHS physicians wanted to prove that syphilis did not attack the nervous systems of blacks because their nervous systems were so, quote-unquote, "primitive."

Now, not treating these men of course condemned them to suffer the ravages of syphilis - not only them, but their children, their wives, their girlfriends. And essentially, this observational study resulted in the PHS physicians waiting for these men to die. It was very important for them to be able to autopsy them in order to try to prove their theory.

And that's exactly what happened. For 40 years, they watched the men and waited for them to die.

CHIDEYA: There are people who keep this legacy alive. But it lives in more than just books like yours and in fictionalized works. Doesn't it live really in the black psyche or how we react to medical professionals?

Ms. WASHINGTON: Absolutely. I think that the fear engendered by the widespread publication of a study has been very powerful in that for many black people it validated fears that they had.

CHIDEYA: Let's move forward. You were not just talking about the past. You're talking about the present. And in some cases towards the end of your book, the future of how race and medicine have interacted. What is one of the most troubling questions of medical experimentation that has gone on recently with African-Americans?

Ms. WASHINGTON: Experimentation with children - extremely troubling. Experimentation with children is always tricky because children cannot give consent, and my research has found that their parents are actually not always the best people to render consent. That's troublesome enough. But what's happened with African-American children is that their parents are much more likely to be bypassed by the system.

African-American children are much more likely to be subjected to non-therapeutic medical research, research that cannot help them. They're also much more likely to be



residents of juvenile institutions or otherwise have their parents removed from the informed consent equation. So we've got a huge pool of African-American children who are subjected to non-therapeutic, sometimes abusive research, for which nobody who is close to them and has their interest at heart has ever given consent.

In the 1970s, Johns Hopkins University sanctioned a researcher who was looking at a genetic anomaly - the XYY. And he was saying that children with this particular genetic anomaly might be more impulsive, which is often sociological parlance for violence.

So he decided to investigate this question, but he investigated by looking at a population of thousands of boys, 85 percent of whom were black. Fast forward 30 years, in New York City, the New York Psychiatric Institute and several revered universities, including Columbia University, engaged in a similar research looking at possible genetic roots of violence, and they did that by looking at only blacks. I read the protocol, which specifically excludes whites. So we have this very tenacious pattern of looking at genetics of violence, but only looking at black boys.

CHIDEYA: Who has oversight of this? Why has there not been more oversight of how these experiments are conducted?

Ms. WASHINGTON: Excellent question. Various federal agencies, most directly the Office for Protection for Research Risks - they are supposed to enforce the Code of Federal Regulations, which says that if you have healthy boys, they cannot be subjected - healthy children, I'm sorry - they cannot be subjected to research that might have more than a, quote-unquote, "minimal risk." And that's how they exonerated these researchers. They looked at the study and decided it had only comprised minimal risks.

I disagree. Here's a study in which boys were given a chemical which has been shown to be poisonous, cardiotoxic, fenfluramine, half of the phen-fen weight combination. It was taken off the market because it was so dangerous, yet it was given to these young boys.

In preparation for the experiment they were taken off all their medications, including medications for life-threatening conditions like asthma, for a week. They were hospitalized overnight. Food was withheld. This constitutes more than minimal risks in my opinion, and yet the government decided that this was an acceptable thing to do to healthy boys.

CHIDEYA: Does this pattern effect how African-Americans are able to advocate for our own health care?

Ms. WASHINGTON: Absolutely. Although it may seem a strange message for someone who has written a book like this, I think it's very important for African-Americans to embrace medical research after, of course, we've educated ourselves.

In a country where we constitute about 13 percent of the population, we constitute one percent of voluntary research subjects. So we're clearly very weary of medical research, and that is harming us.

So if we cut ourselves off from experimental therapies, we're cutting ourselves off from many possible treatments. Also, when we are not present in sufficient numbers in medical research, we are victimized because a drug that may not work as well for us, we will not know that.

CHIDEYA: And what about people who are not interested in research per se, they don't want to volunteer for clinical trials, but are just concerned, well, gee, if I go to the doctor, am I going to be put in a situation that is oppressive. Should we wholeheartedly embrace going to the established medical community with all of our needs.

Ms. WASHINGTON: We have to. I don't think we have a choice there. You have to, number one, find a primary-care physician. Find someone you can trust, because if you're not working in partnership with a physician, your quest for good health is already sabotaged. It's absolutely essential. We have got to find a way to put our fears behind us or conquer them and embrace the health-care system.

We got the greatest health care system in the world in many aspects. And yet African-Americans have an understandable weariness, which is cheating us of years of life and health. So find a doctor who you can trust and work with him or her to improve your health.

CHIDEYA: Well, Harriet, thank you so much.

Ms. WASHINGTON: It's been my pleasure, thank you.

(Sound bite of music)

COX: That was NPR's Farai Chideya with Harriet Washington, author of "Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present." To read excerpts from the book and to see pictures, go to [npr.org](http://npr.org).

Just ahead, the president seeks new funding for the fight in Afghanistan, and stop worrying about that clutter - messy is the new neat.

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