REPARATIONS FOR CONTEMPORARY BLACK HEALTH CARE PROVIDERS AND PATIENTS ADVERSELY AFFECTED BY THE FLEXNER REPORT

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by
Valerie Elizabeth Armstead
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Thesis Approvals:

Dr. Nora Jones, Thesis Advisor, Center for Urban Bioethics

ABSTRACT

Currently only 5.7% of physicians in the United States (U.S.) are Black/African American. This comprehensive analysis explores the significant underrepresentation of Black/African American physicians in the United States, a problem that has persisted for over 100 years. This investigation traces this disparity back to the Flexner report, a document that revolutionized medical education for the benefit of the white population but to the detriment of Black and other vulnerable populations. There is a critical examination of the ethical implications of the Flexner report, arguing that it has contributed to health disparities resulting in shortened lives for Black men, women, and children. Moreover, the roles played by private institutions such as the Carnegie Foundation, the Rockefeller Foundation, the Accreditation Council for Graduate Medical Education and the American Medical Association and the U.S. federal government in initiating, funding or upholding the changes resulting from Flexner's report are delineated. Most importantly, the efforts, as a result of the formation of the National Medical Association to overcome the obstacles placed in front of Black healthcare providers in caring for people of color is revealed. In exposing the damage done to physicians and patients of color there are also proposals of solutions to reverse the ethical harm done because of the Flexner report's implementation, including reparations for Black healthcare providers and patients adversely affected by the Flexner report. In conclusion there is an in-depth analysis of the history and impact of the Flexner report, the ethical and moral imperatives of reparations, and the feasibility and potential impact of these reparations.

DEDICATION

This work is dedicated to my family which include my parents, Ed and Shirley, who were members of what is described as the greatest generation. They were pillars of the educational and social communities of Moorestown, NJ. Having grown up in segregated Baltimore, MD, they never uttered a word of prejudice and left it to me and my five sisters to make those discoveries and judgements on our own. I am grateful for the support and challenges of my husband, three daughters and grandson, who have made me proud of their accomplishments and inspire me to follow my longing for learning in order to make the world better. I am so appreciative of the mentors and friends in education and life who helped me navigate the twists and turns in pivoting, reinventing and refining myself and my brands. Finally, this effort is dedicated to past, present and future health care providers who paved the way for others or reach back knowing that it is truly better to give than to receive.

ACKNOWLEDGMENTS

I am thankful for my teachers and fellow students in the Center for Urban Bioethics at Temple University for opening a whole new world of discovery, methodology, and scholarship in urban bioethics. Specifically, I would like to acknowledge Dr. Nora Jones, my thesis advisor, who reminded me often to incorporate classical ethics into my urban bioethics writing assignments. I appreciate Dr. Jones' use of the slinky metaphor, as its stretching and compressing properties illustrate the interconnectedness of various social, economic, and environmental factors in an urban context and how they influence health and ethical considerations. I will never again look at the slinky as just a toy. I would also like to acknowledge Prof. Nicolle Strand's challenging and valuable assignments to read legal briefs about landmark bioethical laws. Prof. Strand's prescient and all-too-accurate predictions of the loss of human rights due to recent laws enacted or struck down gave me the resolve to write a call to action thesis. I am so grateful for Dr. Melanie Cosby's broad range of teaching, especially about the work of Dr. Derrick Bell and others related to critical race theory. I was so inspired by the enthusiastic, University of Chicago-style thirst for knowledge of Dr. Brian Tuohy in the two years of learning about all things community engagement. I am grateful for the introduction to two great dystopian novelists, Octavia Butler and Margaret Atwood by Dr. Whitney Cabey. The readings were guilty pleasures and harsh reminders of how injustice prevails. Finally I would like to thank, from the bottom of my heart, Catherine Averill, the Good Shepherd Senior Advisor who helped me navigate my way from the start to the finish line.

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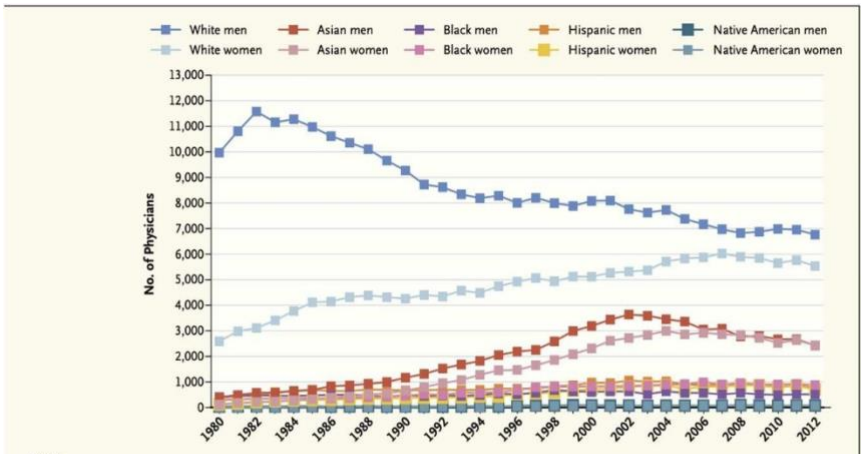
CHAPTER 1

INTRODUCTION: THE CURRENT PERCENTAGE OF U.S. BLACK DOCTORS

Currently only 5.7% of physicians in the United States (U.S.) are Black/African American. (Xierali et al., 2014)(Ansell and McDonald, 2015) (Fig 1)



White									
Men	9972	11,281	10,105	8617	8005	8084	7727	6821	6763
Women	2589	3,775	4,380	4344	4925	5117	5712	5895	5533
Asian									
Men	400	652	924	1526	2188	3191	3452	2777	2427
Women	120	270	516	951	1470	2313	2996	2838	2434
Black									
Men	411	456	468	471	516	614	632	569	517
Women	286	362	405	493	675	824	893	954	880
Hispanic or Latino									
Men	369	629	706	696	741	976	1024	912	766
Women	125	276	345	384	525	721	869	856	696
American Indian or Alaska Native									
Men	30	47	51	31	63	83	77	90	81
Women	3	19	21	30	48	73	57	85	72

Figure 1: U.S. physicians by graduation year, race, ethnicity, and sex, 1980–2012

This number has not changed in over 40 years. In contrast to the small number of Black physicians, Black/African Americans make up 13% of the US population according to the latest census data. (Frey, 2020) The significant under-representation of African American physicians in the United States does not exist or persist by unexplained circumstances. Rather, the lack of expansion of Black health providers in the United States was intentional, unethical, and has contributed to health disparities that result in shortened lives for Black men, women, and children. (Savitt, 2006) The

persistence in resistance to providing just and equal medical and healthcare education to future Black/African American providers has put the U.S. into a crisis. (Byrd and Clayton, 2003; Hill, 2016) This crisis deserves bold action, and steps must be taken to immediately right this wrong. The history of racism and enslavement in America is behind the document that changed medical education for the benefit of the white population and to the detriment of Black and other vulnerable populations. This document is the 364-page Flexner report. (Flexner, 2002; Savitt, 2006)

The purpose of this analysis of the Flexner report is to not highlight the alluring historical details, but to actively propose solutions to reverse the ethical harm done because of the implementation of the flawed thought processes and prejudices that embraced Flexner's report. It is an ethical imperative to establish reparations to halt and reverse the harm done because of the Flexner report.

By setting clear goals and objectives, a proposal on reparations for Black health care providers and patients adversely affected by the Flexner report can help guide a focused and rigorous call to action, while also contributing to broader discussions about racism, health, and social justice in the United States. In light of the latest attack on affirmative action by the United States Supreme Court (Students for Fair Admissions v. Harvard and Students for Fair Admissions v. University of North Carolina)('USCOURTS-mad-1_14-cv-14176-4.pdf', no date), it is time to utilize every resource to right the injustice of long-standing denial of the right to life, liberty, and the pursuit of happiness for the descendants of enslaved and formally enslaved Black African-Americans by the denial of equal medical education and healthcare under the law. (Jayakumar et al., 2023) These laws include the 14th amendment of the U.S. Constitution and title VI of the Civil Rights act. The objectives are the following:

1. Briefly analyze the basic history and impact of the Flexner report on healthcare education and practice in the United States, particularly as it relates to Black healthcare providers, sites of health care for people of color and their patients.

2. To examine multiple impacts of the Flexner report and the ways it perpetuated racial biases and disparities in healthcare, both through its recommendations and its implementation.

3. Explore the ethical and moral imperatives of reparations for Black healthcare providers and patients who were negatively affected by the Flexner report. Bioethical issues related to this goal include accountability, recognition, and justice denied as a result of malfeasance, human rights violations, injustice and unjust enrichment. (deShazo, Hoesley and Vickers, 2021)

4. Investigate possible forms of reparations that can be offered to Black healthcare providers and patients.

5. Assess the feasibility and potential impact of these reparations' initiatives, both in terms of addressing past injustices and promoting greater equity and inclusion in healthcare for today and the future.

CHAPTER 2

THE FLEXNER REPORT

The Flexner Report, published in 1910 and officially titled "Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching," was a landmark publication that played a critical role in the development of the current state of medical education in the United States and Canada. (Flexner, A)

The report was authored by Abraham Flexner, B.A., a prominent U.S. educator and education researcher, who was commissioned by the Carnegie Foundation to investigate and evaluate the quality of medical education in the United States and Canada. The person from the Carnegie Foundation who recruited Abraham Flexner to write the report was Henry Pritchett, who, at the time, was the president of the Carnegie Foundation for the Advancement of Teaching. (Pritchett obit General Notes, Publications of the Astronomical Society of the Pacific, Vol. 51, No. 303, p.302,1939PASP...51.302.) Pritchett believed that the findings of the report would lead to improvements in medical education and ultimately benefit public health. Pritchett was instrumental in securing funding for the report and in selecting Abraham Flexner to lead the study. Pritchett was impressed by Flexner's first book, The American College, A Criticism which critiqued American higher education. (Flexner, 1908)In 1908, Pritchett invited Flexner to undertake a comprehensive study of medical education in the United States and Canada. Although not a physician, Flexner was selected by Pritchett for his writing ability, his disdain for traditional education and lack of vulnerability to the eclectic medical community. The resulting report had a major influence on the development of medical

education and medical practice mainly in the U.S. Flexner and his team visited every one of the 155 medical schools in the two countries, evaluated their facilities, faculty, curriculum, and clinical training programs, and published their findings.

The American Medical Association (AMA) provided funding for Flexner's research and publication of the report, and the organization also endorsed the report's recommendations for improving medical education standards. The AMA's endorsement of Flexner report was not in any way noble because the AMA had firm racist, discriminatory policies for not admitting people of color into their organization until 1968. Furthermore, Darlene Clark Hine argues that the Flexner report's analysis helped the "already reform-minded American Medical Association (AMA) to intensify efforts to upgrade medical education and health care delivery" and "gave to the AMA ideological hegemony … and made it the dominant organization in the field of medicine."(Hine, 1985)

The Association of American Medical Colleges (AAMC) also played a key role in the writing of the Flexner Report. The AAMC was concerned with the varying quality of medical education across the country and wanted to improve standards. Flexner's report provided a scathing critique of medical education in the United States and Canada and became the accepted basis for significant changes in medical education. The AAMC used the report's recommendations to advocate for the closure of low-quality medical schools and the consolidation of medical education into university-based institutions with rigorous standards. In this way, Flexner served as the henchman for three masters: Henry Prichett through the Carnegie foundation, the AMA and AAMC. The report was highly critical of many aspects of medical education at the time, including the use of inadequate

facilities, underqualified faculty, and a flawed curriculum that relied too heavily on rote memorization of facts rather than active learning and problem-solving. The report also called for the standardization of medical education and the establishment of rigorous accreditation standards for medical schools. This would turn out to be a double-edged sword for many of the Black medical schools that were already financially struggling as elaborated in Chapter 3.

CHAPTER 3

THE IMPACT OF THE FLEXNER REPORT

Flexner's report impact was profound and far-reaching. (Faunce and Gatenby, 2005; Huwendiek, Mennin and Nikendei, 2007). Many of the medical schools that were found to be inadequate or substandard were closed or merged with other institutions, and the remaining institutions were required to implement significant, challenging reforms to meet the new standards set out by the report. In total, 89 of 155 schools surveyed closed. (Redford, 2020)

Specific impacts of the Flexner Report on American and Canadian medicine include:

- Average physician quality increased significantly (O'Brien and Irby, 2013)(Fishbein, 1947)
- Medicine became a lucrative and well-respected profession. (Board, 1999)
- A physician had to receive at minimum six years, preferably eight years of post-secondary education, typically in a university setting. (Hudson, 1972)
- Medical education was based on research, specifically in the fields of physiology and biochemistry. (Savitt, 2006)
- Medical research followed the same protocols as scientific research(Beck, 2004)
- The state government had to approve the founding of any medical school and medical schools were subjected to state regulation. (O'Brien and Irby, 2013)

- The state branches of the American Medical Association oversaw all the conventional medical schools in each state. (Johnson and Green, 2021)
- Closure of most rural medical schools(Ludmerer, 2010)
- Closure of non-traditional healing schools(Thomas, 2001)(Stahnisch, Verhoef, and others, 2012)
- Closure of most (five of seven) women's medical schools (Barkin et al., 2010)
- Closure of five out of seven Black medical colleges in the United States. (Steinecke and Terrell, 2010; Miller and Weiss, 2012)
- Specific racist & sexist commentary to limit the education of "The Negro" & women (pp. 180-181 & 178-179 of the report)(Flexner, 2002)

While some of recommendations or reforms had important positive contributions to the profession by allowing for incontestable improvements, considerable harm was done to the profession and to patients through detrimental changes. Most significantly for the scope of this work, the report's recommendations reduced options for Black medical students and perpetuated racist and sexist attitudes in medical education.

The Impact of the Flexner Report on the Two Remaining Black Medical Schools

The two remaining Black medical schools, Howard Medical School in Washington D.C., and Meharry Medical College in Nashville, TN still faced struggles due to the lack of resources. Reprehensibly, the intended purpose of keeping these schools open was to support the explicitly racist assumptions about lack of hygiene of Black people and their spread of disease to white people in their proximity. According to Flexner, it was the duty of Black doctors to take care of their own. Furthermore, denial of justification for Blacks to have surgery and preventing Black physicians from acquiring

surgical training limited the Black doctors' skills upon graduating. The General Education Board (founded by John D Rockefeller) also provided funds for existing Black medical schools for Black students. (Morsy, 2023) The General Education Board, however, encouraged Black medical graduates to stay working in the rural South in step with Flexner's report. Schools with graduates that established private medical practices in the North received less funding. Additionally, fellowships awarded to Black medical programs discouraged scientific research projects and encouraged more remedial education. (Morsy, 2023) In the report, Abraham Flexner stated that Black schools should focus on "hygiene rather than surgery" and noted that for Black doctors, "their duty calls them away from large cities to the village and the plantation."(Ward, 2003)

The Impact on Black Medical Practitioners

Consequences of the Flexner Report for Black Medical Practitioners and Communities benefitted the existing hegemony of the AMA, certain charities, the AAMC, state licensing boards and even the Accreditation Council for Graduate Medical Education (ACGME).

The Flexner report severely decreased the number of Black physicians in the US. Before the publication of the Flexner report in 1910, there were more Black physicians in the United States relative to the size of the total Black population. (Harley, 2006)(Figure 3) This is because medical schools during this period were not standardized, and many medical schools accepted Black students. (Epps, 1999) However, after the Flexner report was published, many medical schools closed or raised their admission standards, making it much more difficult for Black students to attend medical school. This led to a

significant decrease in the number of Black doctors in the United States that has persisted for over one hundred years.

There are several factors that contribute to the low number of Black physicians in the present-day United States. Major factors include the lack of access to higher education and financial resources that many Black students face. These barriers make it difficult for historically disadvantaged persons to pursue careers in medicine, as a significant amount of time and resources are required to successfully compete and complete prerequisites. Additionally, systemic racism and biases within the healthcare and education systems create obstacles for Black individuals pursuing careers in medicine. This results in lower acceptance rates into medical schools and creates challenges for Black physicians in the workplace, including fewer professional opportunities and lower salaries. The social justice perspective or lack thereof in reviewing obstacles to diversifying the healthcare workforce is elucidated by Wilbur. (Wilbur et al., 2020)

The Effect on Black Medical Academicians and Post Graduate Medical Education

The low number of Black medical graduates relative to the Black population also resulted in a disproportionately low number of Black medical school faculty. There is also a lack of diverse representation in medical school faculty, which contributes to a lack of mentorship and support for Black students pursuing careers in medicine, especially academic medicine. (Roberts et al., 2020)(Cerdeña, Rehman and Hardeman, 2020)

Currently only 3% of medical school faculty members in the US are Black and 4% are Latino. (Xierali et al., 2014; Person et al., 2015)(Figure 2)(Bennett and Ling,

2021) Compared to the actual makeup of the population, 13% of the U.S. population identifies as Black or African-American. (Frey, 2020)

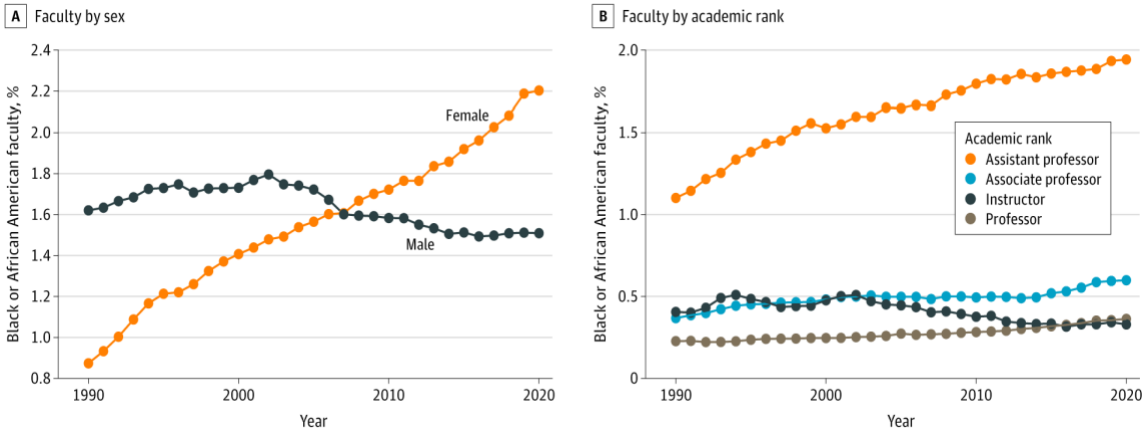


Figure. 2: Proportion of faculty self identifying as Black or African-American at US Medical schools, 1990–2020 by sex and academic rank

Moreover, AMA's exclusion and resistance to public health issues until 1968, in the spirit of the Flexner report, was a serious setback for a Black post medical education. (Baker et al., 2008)(Mitchell, 2020) Medical training & hospital services were segregated in much of the US, and still are to some degree, due to lack of Black medical school graduates to fill post-graduate positions throughout the country. The practice of filling these post-graduate training positions with international medical graduates, who still benefit from their status compared to Black American physicians, deserves a targeted review when focusing on health disparities in vulnerable populations. (Jenkins, 2019)(Carmody and Nguemeni Tiako, 2021) A projection by researchers estimate that had the number Black medical schools not changed at the time of the Flexner report, there would be approximately 30,000 to 35,000 more Black physicians in the United States today. (Campbell et al., 2020)(Table 1.)

			Additional projected graduates from year of school closure to 2019, No.	
School	**Estimated graduates per year, mean**	**Years between school closure and 2019, No.**	**Steady expansion model[a]**	**Rapid expansion model[b]**
Flint Medical College of New Orleans University, Louisiana	5.27	108	5862	7396
Knoxville Medical College, Tennessee	2.60	109	5678	7300
Leonard Medical School of Shaw University, North Carolina	11.06	101	5750	7102
Louisville National Medical College, Kentucky	4.17[c]	107	5646	7216
University of West Tennessee College of Medicine and Surgery-Memphis, Tennessee	6.74	96	4837	6301
Total projected graduates				
All 5 schools	NA	NA	27,773	35,315
Leonard Medical School and University of West Tennessee only	NA	NA	10,587	13,403

[a]Assumes an expansion rate of 0.9 graduates per year to a maximum of 100 graduates per year.
[b]Assumes an expansion rate of 1.3 graduates per year to a maximum of 100 graduates per year.
[c]Mean number of graduates based on the lower limit of the known total number of graduates.

Table 1: Projected Estimates of Additional Graduates From Closed Historically Black Medical Colleges (Campbell, et al., 2020)

This is an important projection because it has been shown that concordance with ethnicity with patients and providers results in better health and life expectancy especially for African Americans. (Eken et al., 2021) Separate and unequal resources available to

Black and minority providers and patients, including Jews & other ethnicities, existed until the mid-20th century. (Halperin, 2019)

An organization, founded out of necessity to aid in the education of Black medical students and Black health care professionals is the National Medical Association. The National Medical Association (NMA) is the largest and oldest national organization representing African American physicians and their patients in the United States. It was founded in 1895 as the National Association of Colored Physicians (NACP) and renamed the NMA in 1901. The organization at its founding was non-exclusionary and has continued to welcome and help healthcare professionals of all ethnicities. At the time of its founding, African American physicians were excluded from membership in the American Medical Association (AMA) and other medical organizations due to the racial segregation that existed in the United States.

The NMA played a key role in the fight for equal access to medical education and healthcare for African Americans that was denied by the Flexner report recommendations. The NMA advocated for the desegregation of hospitals and medical schools and fought against discriminatory practices such as exclusion from medical societies and poor working conditions for African American physicians. The NMA also established its own medical journal, the Journal of the National Medical Association, in 1909, which remains in publication today.

Over the years, the NMA has expanded its focus beyond the needs of African American physicians and their patients to address broader issues in healthcare and medicine. Its mission now includes promoting diversity and inclusion in medicine,

addressing health disparities affecting minority populations, and advocating for policies that improve access to quality healthcare for all.

The NMA has mitigated the harms of the Flexner report to physicians of color and their patients by explicitly focusing on fostering careers that the broader medical establishment has systematically excluded. Furthermore, the establishment of the NMA is relevant to urban bioethics by exemplifying solidarity and justice by specifically stating in its a non-exclusionary Article II of its original Objects. (Mitchell, 2020)

Impact on Black Hospitals

Despite valiant efforts to establish hospitals for Blacks and other people of color in the face of state-condoned segregation, many of these hospitals closed for several reasons while their white counterparts ironically saw increased support. The Hill-Burton Act, officially known as the Hospital Survey and Construction Act, was a U.S. federal law enacted in 1946. The act aimed to improve access to healthcare services by providing federal funds for the construction and modernization of hospitals and other healthcare facilities. Under the Hill-Burton Act, the federal government provided grants and loans to assist states and hospitals in building, expanding, or renovating healthcare facilities. In return for the financial assistance, hospitals and facilities were required to provide a reasonable number of services to people in need, regardless of their ability to pay. The act played a significant role in the expansion of the American healthcare infrastructure, particularly in underserved areas. It led to the construction of numerous hospitals and healthcare facilities across the country, thereby increasing access to vital medical services for many communities.

Since the Hill-Burton Act was implemented over seven decades ago, it provided funding for an exhaustive list of hospitals some are still open today. There are several well-known hospitals that received assistance provided by the Hill-Burton Act and thrived to enormous notoriety & success such as the following:

1. Massachusetts General Hospital - Boston, Massachusetts
2. Mayo Clinic - Rochester, Minnesota
3. Cleveland Clinic - Cleveland, Ohio
4. Johns Hopkins Hospital - Baltimore, Maryland
5. Yale-New Haven Hospital - New Haven, Connecticut
6. Barnes-Jewish Hospitals - St. Louis, Missouri

It is important to note that many hospitals across the United States received funding through the Hill-Burton Act, and this is just a sample of well-known hospitals that have acknowledged their support. A comprehensive list of hospitals can be found in the U.S. Department of Health and Human Services or specific state records under the Hill-Burton program. ('SERIALSET-11497_00_00-045-0581-0000.pdf', https://www.govinfo.gov/app/details/SERIALSET-11497_00_00-045-0581-0000, last visited 07.17.2023)

Black hospitals founded or assisted by the Hill – Burton act include:

1. Howard University Hospital - Located in Washington, D.C., it was founded in 1862 and became the teaching hospital for the Howard University College of Medicine.

2. Meharry Medical College - Located in Nashville, Tennessee, Meharry established a hospital in 1938 to serve the African American community and provide clinical training for its medical students.

3. Provident Hospital - Located in Chicago, Illinois, Provident was one of the first Black-owned and operated hospitals in the United States, founded in 1891. It received Hill-Burton funding for expansion and improvement in the 1940s.
4. Homer G. Phillips Hospital - Located in St. Louis, Missouri, it was named after Homer G. Phillips, Esq. who raised a significant amount of money to build a Black hospital in St.Louis, but he was murdered before construction was completed. The hospital opened in 1937 and provided medical services to the predominantly Black community until its closure in 1979.

Compared to the illustrious hospitals in the previous paragraph the separate but unequal precedent buried in the Hill-Burton act resulted in closure of most of the Black hospitals assisted or established by it.

Nonetheless, these hospitals played a critical role in providing medical care for African Americans during a time of segregation and limited access to healthcare facilities.

Finally, the early days of Veterans Administration (VA) health system consisted of segregated hospitals and denial of Black physicians to have admitting privileges in them are deplorable examples of the way that U.S. taxpayers supported unethical, unjust practices.

CHAPTER 4

THE ETHICAL AND MORAL IMPERATIVES OF REPARATIONS FOR BLACK HEALTHCARE PROVIDERS AND PATIENTS DUE THE FLEXNER REPORT

Given the long-standing salutary acceptance of the Flexner report, it is a wonder why questions about its ethical nature did not arise sooner than its 100th anniversary The existence and history of Flexner's report are typical examples of buried, inconvenient, unethical foundations of professions or practices that demand action in the form of reparations due to the extent of the damage done to vulnerable groups and populations. It is ethically obligatory to expose the damage that has been done to the group of Black physicians and patient population and demand reparations that can eliminate that harm and repair the broken healthcare system in the United States.

Considering the definition of ethics, it is obvious that the underlying intentions of the Flexner report were unethical. As a reminder, ethics is a branch of philosophy that deals with moral principles concerning what is considered morally right or wrong. It encompasses the study of values, virtue, and moral duty, and helps guide individuals, groups, and societies in making decisions and behaving ethically. Ethics explores questions about what actions are morally acceptable, how individuals should live their lives, and how one should treat others. It provides a framework for evaluating and analyzing ethical dilemmas and enables the development of principles and guidelines for ethical behavior. Within the scope of the Great Migration to northern U.S. cities by Black Americans from the rural South who were refugees from the Jim Crow era, urban

bioethical issues arise. Urban bioethics refers to the application of ethical principles and considerations to address moral issues that arise within the context of urban environments. It focuses on the interplay between urban living, public health, and biomedical advancements, while considering the unique challenges and opportunities that arise in densely populated areas. Urban bioethics encompasses a wide range of topics, including but not limited to, access to healthcare, environmental justice, social determinants of health, genetic research, emerging technologies, public health interventions, disparities in health outcomes, healthcare resource allocation, and ethical implications of urban policy decisions. Those who focus on the discipline of urban bioethics seek to ensure that ethical principles, such as justice, autonomy, beneficence, and non-maleficence, are applied to urban populations in an inclusive and equitable manner, considering the diverse socioeconomic, cultural, and environmental factors that influence the well-being of individuals and communities residing in urban areas. Urban bioethics aims to promote public dialogue, evidence-based decision making, and the development of ethical guidelines and policies to address the unique ethical challenges of urban living.

Despite the allure of northern urban centers in U.S. as being safe havens from Jim Crow persecution, some of the same forms of discrimination and bigotry persisted openly as well in more cloaked forms, thus necessitating the attention of urban bioethicists. A contemporary example of urban bioethics violation is the lead poisoning crisis in Flint, MI that occurred when politicians made a cost-saving decision to divert a lead-contaminated water source to supply public drinking water to a community that was predominantly low-income or people of color. (Hanna-Attisha et al., 2016)(Lee, 2017)

In reviewing the history surrounding the Flexner report and why it was unethical, through an urban bioethics' lens, the initial well-intended purpose to improve medical education and healthcare in the United States and Canada was corrupted by outside and innate forces that were contaminated by racism, sexism, elitism, and condescension. Moreover, extreme prejudice, greed and self-serving policies also condoned the exclusion of populations, disciplines, services, and practices that resulted in profit for some and denial of a pathway to prosperity, freedom, and justice for others.

Before the Flexner Report of 1910, medical education in the United States was largely unregulated. Medical schools varied greatly in quality, and there was no universally accepted set of ethical principles for medical professionals. However, the Hippocratic Oath, a document dating back to ancient Greece that outlines ethical principles for medical practice, was a prominent influence on medical ethics.

One might ask what other medical ethics existed before Flexner's report. In addition to the Hippocratic Oath, ethical considerations for medical professionals were primarily based on the traditions and values of individual medical schools and the medical profession. In general, medical professionals were expected to prioritize their patients' well-being above all else, and to act with honesty, integrity, and professionalism. However, there was little formal guidance or oversight of medical ethics prior to the Flexner Report.

Given the task set before him, whether Abraham Flexner had a moral compass to take an ethical approach to writing the report is an interesting question. He was the son of a large orthodox Jewish family who grew up in Kentucky. (Gordon, 1971) He was agnostic in his adulthood but later in life worked actively to bring many Jewish scientists

out of Nazi Germany, including Albert Einstein, which was a noble endeavor. (Gunderman et al., 2010) Flexner did not write extensively on ethics. He studied psychiatry at Harvard for a short period time and received no post-graduate degrees. (King, 1978) Nonetheless, he did contribute to the discourse on ethics in education through his work as the founder and first director of the Institute for Advanced Study in Princeton, New Jersey. In his writings and speeches, Flexner emphasized the importance of educating the whole person and cultivating ethical principles and values that would guide individuals in their personal and professional lives. He believed a liberal education that emphasized critical thinking, intellectual curiosity, and ethical responsibility was essential for the development of responsible citizens and leaders.

Despite alluding to individualized ethical responsibilities being necessary, recommendations promoting a firm understanding of and commitment to medical ethics as a basis of medical professionalism were not emphasized in Flexner's report.(Faunce and Gatenby, 2005) It appears that he was selective in his beneficence and showed poor judgement by making derogatory statements that were scientifically inaccurate.

Bioethicists often compare the moral turpitude in the United States medical system to the vision of Sir William Osler's of what modern medicine should look like with egalitarian principles, rational science and inclusive spirit versus what he observed in his time as "a bigoted, intolerant spirit" and "distinctions of race, nationality, color and creed".(Osler, 1897) Discussions of this difference between the two impactful figures in medicine often describe Flexnerians versus Oslerians.(Dornan, 2005)

Furthermore, Flexner's praise for the scholastic basics of German medical education appears insalubrious when the ethical transgressions in the form of human

rights violations by prominent Nazi doctors were revealed at the Nuremberg Trials.(Cohen Jr, 2010)

Modern Impact and Responses to Flexner Report

The ethical implications of the Flexner report are far reaching. The report had a major impact on medical education and healthcare in the United States that still has negative ethical and urban bioethical impact for well over 100 years. A major negative ethical implication of the Flexner report was that it resulted in the closure of many medical schools that primarily served minority and low-income communities. This led to a decrease in the number of physicians who were trained to serve these communities and a dearth of Black physicians to this present day. Therefore the Flexner report has had negative consequences for access to healthcare and health disparities, especially for Black Americans. (Menefee, 1996)

An independent panel of experts, convened by the American Medical Association (AMA) Institute for Ethics, analyzed the roots of the racial divide within American medical organizations. Summarized in the first of a 2-part report, the AMA Institute for Ethics describe 2 watershed moments that helped institutionalize the racial divide. The first occurred in the 1870s, when 2 medical societies from Washington, DC, sent rival delegations to the AMA's national meetings: an all-white delegation from a medical society that the US courts and Congress had formally censured for discriminating against Black physicians; and an integrated delegation from a medical society led by physicians from Howard University. Through parliamentary maneuvers and variable enforcement of credentialing standards, the integrated delegation was twice excluded from the AMA's meetings, while the all-white society's delegations were admitted. AMA leaders then

voted to hand the power to select delegates to state societies, thereby accepting segregation in constituent societies and forcing African American physicians to create their own, separate organizations.(Mitchell, 2020)

The second watershed involved AMA-promoted educational reforms, including the 1910 Flexner report. Straightforwardly applied, the report's population-based criterion for determining the need for physicians would have recommended increased training of African American physicians to serve the approximately 9 million African Americans in the segregated south. Instead, the report recommended closing all but 2 Black medical schools, helping to cement in place an African American educational system that was separate, unequal, and destined to be insufficient to the needs of African Americans nationwide.(Baker, 1999) (Baker, 2014). This admission of guilt or mea culpa by the AMA in its role in propagating a slew of unethical transgressions that essentially screamed for the establishment of the discipline of bioethics is damning. It is therefore ethically imperative that reparations specifically for the harm committed in the name of the Flexner report be established in a way that can potentially expeditiously end several disparities that plague our society because of (to paraphrase Sir William Osler) bigotry, intolerance, and racism. Most infamously, the Flexner report emphasized a focus on scientific research and the biomedical model of healthcare, which led to a neglect of other social and environmental factors that contribute to health outcomes.(Sox, 2007) This narrow focus has had ethical implications in terms of the quality of care provided, as well as disparities in health outcomes. Continued health care disparities for vulnerable populations in America has had remarkable consequences in that individuals in the research community have been able to benefit significantly by reporting on these

disparities in scientific journals. Often solutions do not accompany these reports , which comes as no surprise to cynics and vulnerable populations. This hand wringing without bringing about effective solutions needs to be called out for what it is: mainly much ado without doing much.

Flexner's report led to decreased trust in the medical establishment by vulnerable populations. The emphasis on scientific rigor in medical education often came at the expense of the humanities and social sciences, leading to a narrower and more technocratic approach to medicine. The fervor for generation of research publications that were clinically-based, without regard to patient safety resulted in human rights violations that necessitated the creation of specific bioethical reports and guidelines to protect research subjects and the formation of internal review boards.(Enfield and Truwit, 2008) There is still mistrust and reluctance to participate in clinical trials by Black and Brown populations due to infamous human rights violations committed to advance medical research.

Additionally, the Flexner report's emphasis on medical schools as the primary site of physician education and training eventually led to a decline in apprenticeship models and a reduction in community-based learning and community engagement. Ironically, most U.S. medical schools are surrounded by impoverished neighborhoods with resultantly stressed neighbors and families who do not enjoy good health or safety (Mullins, 2003)

Additional Harms of Omissions and Oversights as a Result of Flexner's Report

Perhaps the study of pain was an afterthought for Flexner who was almost obsessed with germ theory, however, modern bioethicists are strident in drawing

attention to the major moral failing of the medical profession in the last century by its inability to properly address and care for the problem of pain. The American medical profession has been criticized for its handling of pain management, particularly considering the opioid epidemic. Some of the main failings include the over prescription and overuse of opioid painkillers, the under-treatment of pain in certain populations (such as elderly patients or patients of color), and a lack of education and training among healthcare providers about alternative pain management strategies. Additionally, there has been a historical tendency to view pain as a subjective experience, leading to Black and Brown patients being dismissed or not taken seriously when reporting their symptoms.(Saeed et al., 2023)

The totally unethical, greed driven attitude of U.S. physicians in dealing with pain caused the opiate epidemic which has cost lives and destroyed families.

There have been several other bioethical failings of the medical profession in the United States. One of the most significant is the historic mistreatment of African American patients in medical research. For example, the infamous "United States Public Health Service Study of Untreated Syphilis Study at Tuskegee" which saw U.S. federal institutions funding unethical research that withheld syphilis diagnoses and available treatments from participants, resulting in death and preventable suffering and infections .(Vijayan, Cortés-Penfield and Harris, 2020) Similarly, the forced sterilization of people deemed "unworthy" of procreation, such as those with disabilities or of certain races, persisted in the U.S. until at least the 1970s (Reilly, 2015). Another example is the inadequate informed consent practices during medical experimentation on vulnerable populations, such as prisoners and mentally ill individuals. These failings have

contributed to a longstanding history of mistrust and suspicion towards the medical profession among marginalized communities.

Flexner's sexist attitude about women and the report's recommendations on medical education were used to create new barriers for women and people of color who were seeking to become physicians. The report's recommendations on entrance requirements, curricula, and accreditation standards disproportionately impacted non-white and female physicians, making it harder for them to enter the medical profession.(Reed and Buddeberg-Fischer, 2001)(Griffin, 2019)

Overall, the Flexner Report had a profound negative social impact on American medicine and medical education. However, it also had both positive and negative implications for bioethics, particularly in terms of creating new opportunities for scientific advancement, while also reinforcing existing structures of exclusion and marginalization.

CHAPTER 5

INVESTIGATE POSSIBLE FORMS OF REPARATIONS THAT CAN BE OFFERED TO BLACK HEALTHCARE PROVIDERS AND PATIENTS

The public apologies and acts of contrition from organizations responsible for enabling and implementing Flexner's report are insufficient in that too little change has occurred to end inequality of healthcare for BIPOC and other vulnerable populations. These public machinations have the same limp effect as thoughts and prayers after the all-too-frequent mass school shootings in the U.S.

Tangible reparations include financial compensation such as tuition remission, scholarships, mentoring and pathway programs, policy reforms and most importantly replacing the number of Black medical schools that were closed. The funding for the latter should come from all organizations or their vestiges they were responsible for the funding and promotion of the Flexner report. These organizations include the Carnegie Foundation, the American Medical Association (AMA), the Association of American Medical Colleges (AAMC) , the Accreditation Council for Graduate Medical Education (ACGME), state medical societies that historically prevented physicians of color from obtaining licensure or limiting their practice due to discrimination, healthcare institutions with discriminatory bylaws against Black healthcare practitioners and patients, and the

U.S. federal government for implementing laws or acts that harmed Black physicians, patients or historically Black health care institutions. The classes of individuals and institutions harmed because of the implementation of Flexner's report were identified extensively in Chapter 2. Furthermore, just as descendants of Americans

of Japanese ethnicity who were interred in World War II and indigenous peoples received reparations for the harm done to previous generations, reparations are owed to African Americans harmed by the Flexner report.

CHAPTER 6

ACTIONS TO IMPLEMENT PROPOSED REPARATIONS FOR BLACK PHYSICIANS AND PATIENTS HARMED AS A RESULT OF THE FLEXNER REPORT

There have been various commissions and initiatives to review the possibility of reparations for descendants of formerly enslaved African Americans in the United States. One of the notable efforts was the establishment of the Commission to Study Reparation Proposals for African Americans Act, also known as H.R. 40. H.R. 40 was first introduced in Congress by Representative John Conyers Jr. in 1989 and, after his retirement, was reintroduced by Representative Sheila Jackson Lee.

The purpose of H.R. 40 was to create a commission to examine and report on the history of slavery in the United States, the effects of slavery and racial discrimination on African Americans, and to consider reparations proposals for descendants of enslaved Africans. While the bill has been reintroduced multiple times, it has yet to be passed into law.

Additionally, there have been other local and state-level efforts to address reparations. For example, in 2020, the City Council of Asheville, North Carolina, passed a resolution to apologize for the city's historic role in slavery and racial discrimination and to begin the process of reparations for the African American community.

The 14th Amendment of the United States Constitution and the Civil Rights Act can be used as legal frameworks to seek redress for the damage caused by historical events, policies, or actions such as the Flexner Report. However, it's important to note

that while they may be relevant, specific legal arguments need to be developed and assessed by legal experts. As delineated below:

1. The 14th Amendment: The 14th Amendment, ratified in 1868, guarantees equal protection under the law to all citizens. It can be argued that the damage caused by discriminatory policies, like those perpetuated by the Flexner Report, violated this guarantee. However, it is crucial to establish a direct link between the discriminatory policies and the harm or disadvantages suffered by individuals. These links have been established in Chapter 2.

2. The Civil Rights Act: The Civil Rights Act of 1964 prohibits discrimination based on race, color, religion, sex, or national origin. It can be employed to challenge discriminatory practices resulting from the Flexner Report, particularly if evidence can be presented to demonstrate a disparate impact on certain racial or ethnic groups. However, it is important to note that the Civil Rights Act primarily addresses contemporary acts of discrimination and may have limitations in addressing historical injustices. These contemporary acts are low-hanging fruit considering the admission of guilt by the AMA & AAMC. Public records can be used to discover discriminatory acts by licensing boards and hospitals.

To initiate these claims for reparations, engaging legal professionals, such as civil rights lawyers or scholars specializing in constitutional law will be necessary. They can provide guidance on developing a specific legal argument, gathering evidence, and navigating the complex legal processes. It is anticipated that the work from legal scholars and civil rights attorneys will be pro bono work. A task force for interested parties and stakeholders to start this can be formed on social media.

CHAPTER 7

DISCUSSION

It's worth noting that the topic of reparations is complex and controversial, with a range of viewpoints and perspectives. The discussions and debates surrounding reparations should be held on both legislative, private, and public platforms. Engagement of the harmed medical community as well as the community of harmed patient population is essential to ensure justice and inclusion. It is important to abide by "Nothing about us, without us" mantra that was popularized in the rights for disabled peoples movement to ensure empowerment, equity and inclusion in the implementation of the proposed reparations.(Charlton, 1998) Moreover, Bioethics can be used to remedy the negative consequences of the Flexner report. Bioethicist, Dr. Charlene Galarneau wrote emphatically that addressing anti-Black racism is essential to the work of bioethics in the United States.(Galarneau, 2022)(Fletcher et al., 2022)

For example, an approach to remedying these negative effects could be to apply an ethical lens. Ethical principles such as justice, beneficence, and non-maleficence can be used to address issues such as equity in medical education and healthcare, patient-centered care, and the promotion of diversity in the healthcare workforce.

For example, medical schools could prioritize recruiting and admitting underrepresented minorities and women, as well as applicants from diverse socioeconomic backgrounds. This strategy is also known as affirmative action. This would promote equity and justice in medical education while also helping to address healthcare disparities. Additionally, medical education could be designed to focus on

patient-centered care, which emphasizes collaboration and communication between doctors and patients.

Finally, medical organizations could prioritize the promotion of diversity in the healthcare workforce, not only by recruiting and mentoring minority students and physicians but also by addressing systemic barriers that prevent minorities from achieving leadership positions in healthcare. By applying ethical principles, it is possible to address some of the negative aftermaths of the Flexner report and develop a more equitable and patient-centered healthcare system. One of the best reparations that would benefit the health care crisis is to establish a national health care system which is in place in many modern, model countries throughout the world.

Arguments against reverse discrimination for implementing reparations for transgressions against vulnerable populations in consideration of the construct of race continue to exist. The idea and coinage of the word race is an inaccurate term and is problematic in race-obsessed societies such as that which exists in the U.S.(Bhopal and Donaldson, 1998) Nonetheless, the notion of reverse discrimination is a smoke screen in an attempt to bolster the cause of White privilege and white supremacy.

White people are not discriminated against in academic medicine. In fact, white people are overrepresented in academic medicine compared to their representation in the general population. According to a 2019 study published in the Journal of the American Medical Association, white people make up nearly 70% of faculty members in academic medicine, while only making up 60% of the general population. This overrepresentation of white people in academic medicine is due to a variety of factors including nepotism, systemic racism, and economic adversity which have resulted in a lack of diversity in all

health professions.(Ansell and McDonald, 2015). The equal protection clause of the 14th amendment has been used to analyze complex social and economic models, such as housing and education and has moved those systems to greater racial equality. The equal protection clause is at the heart of our national laws and ethos and, as a claim for fair treatment from government, has considerable rhetorical power. Menefee presents an analysis of major health policies dealing with training of physicians, construction of hospitals, and financing of personal health care. He suggests it demonstrates a health system rooted in racial discrimination and perpetuating racial discrimination in education, employment, and housing. The history of successes using this analytical framework in other areas of social policy validates its consideration by health policy analysts for further research.(Menefee, 1996; Acosta and Karp, 2018)

The lack of diversity in all healthcare disciplines in the United States because of Flexner's report needs to be dealt with immediate & intense prioritization as the crisis in healthcare will ruin not just healthcare, but the entire nation.

Mea Culpas from the Hegemonic Leaders of Healthcare

The following action by the leading academic medical organization is a good example of bending the arc of truth towards justice.

The official recognition, by the AAMC, that, despite the Flexner report improving some aspects of medical education in the United States and Canada, the flagrantly racist and sexist comments by Abraham Flexner in the document have continued to have an enduring, negative impact on the medical education of Black people and the education of other Black health professionals, including women.(Barkin et al., 2010; Steinecke and Terrell, 2010) Furthermore, the suggested, pervasive notion that Black physicians should

occupy a second-class place in medical practice and education in the Flexner report has resulted in health disparities that continue to negatively impact health policy, ethics, and the health of Black Americans and other vulnerable populations of the United States.(Menefee, 1996; Deshazo, Smith and Skipworth, 2014; Goldberg et al., 2023)

An excerpt from the AAMC, in elaborating on why they were removing the name of Abraham Flexner from its highest award for medical education, which was established in 1958, talks non-specifically about reparations:

"While the closure of schools that educated women and Black physicians has had an enormously negative impact on the profession, it is Flexner's racist and sexist views that have prompted the AAMC to act, says David Acosta, MD, AAMC chief diversity and inclusion officer .(Acosta and Ackerman-Barger, 2017; Acosta and Karp, 2018; Acosta and Skorton, 2021)

In his report, Flexner wrote that while women were not barred from applying to medical school, they "show a decreasing inclination to enter it" — and that those who did had "obvious limitations."

Black students, he said, should be trained as "sanitarians" rather than surgeons and their primary role should be to protect White people from disease. A well-taught negro sanitarian will be immensely useful; an essentially untrained negro wearing an M.D. degree is dangerous," Flexner wrote.

"Flexner's racist and sexist views, pejorative language, and unsubstantiated statements negatively impacted physician training for women and Black/African Americans and adversely impacted the health of the Black and African American communities in the United States," Acosta says. "We must not ignore medicine's racist

history and make every effort toward reparation when this history is identified."(Beck, 2004; Hill, 2016)

CHAPTER 8

CONCLUSION

Action in establishing reparations to remedy the effects of the Flexner report and replace at least 5 of the Black medical schools closed after it was published is an ethical imperative. Better yet, re-establishing 11 Black medical schools and healthcare institutions to account for the original thirteen, would solidify the possibility of equality in health care. Affirmative Action ideally addresses past and current discrimination. The closure of Black medical schools because of the Flexner report is a major injustice, reflecting the systemic racism and discrimination that has been prevalent throughout American history. Restoring these medical schools could be seen as an attempt to rectify this injustice, and to ensure that Black doctors have access to the same educational opportunities as other medical students.

However, there are ethical considerations that need to be considered when considering such a proposal. One potential concern is that the restoration of Black medical schools could result in a form of segregation, where Black students are exclusively educated in separate institutions from their white counterparts. This could perpetuate racial discrimination and exacerbate the existing racial divide in the medical profession. However, the DeBakey High school for Health Professions is an example of academic excellence with a student body that is 89% underrepresented minorities and a successful pathway to medical professions including medicine.(Roberts, 1999)(Johnson, Charner and White, 2003)

Another ethical consideration is whether the restoration of these medical schools is the most effective way to address racial disparities in medical education. Once the truth about the Flexner report is revealed publicly, the suggested reparations will be seen as more than symbolic gestures to restore these institutions. Reparations may not address the underlying systemic issues facing minority students in the medical field, such as unequal access to resources or bias in the selection process but the effect of representation and ethnic concordance will improve outcomes. This effect will be better for everyone and the proof will manifest itself in the pudding.

Ultimately, the decision to restore Black medical schools requires bold action while establishing commitments to address broader issues of inequality in healthcare. Dr. Martin Luther King, Jr.'s comments on health care inequality being inhumane have been heavily quoted and are contained in the Appendix. A thorough, formal analysis of the impact of the restoration and consideration of programs or interventions that will address the existing disparities in a more comprehensive manner is warranted.

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APPENDIX A

DR. MARTIN LUTHER KING'S WORDS ON HEALTH CARE INEQUALITY

On March 25, 1966, in Chicago at a prayer conference before his speech at the second convention of the Medical Committee for Human Rights (MCHR) (Martin Luther) King said (in part):

"We are concerned about the constant use of federal funds to support the most notorious expression of segregation. Of all of the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death."

"I see no alternative to direct action and creative nonviolence to raise the conscious of the nation. (Galarneau,2018)