Minority Distrust of Medicine:

A Historical Perspective

Robert Baker, Ph.D.

Abstract

Recent philosophical work has disclosed a host of problems in our apparently natural ways of classifying things. The contemporary classification of certain groups as "minorities" exemplifies some of these problems. I argue that these classifications are arbitrary and misleading. Through examining several of the most significant ethical moments in the history of modern medicine, including the thought and conduct of Nazi physicians, the Tuskegee study, Beecher's questioning of post-war research practices and Percival's enunciation of a universalist ethic for physicians, I make a case against racial and ethnic classification of patients. Such classifications can play a destructive role in determining the sort of health care which minorities receive. Embracing them, even with the intent of improving the lot of those who do not fare well in the present health care environment, is subversive of the egalitarian stance which has been central to medical ethics since Hippocrates.

Key Words: Allocation, discrimination, ethnicity, egalitarianism, Hippocratic Oath, history of medical ethics, medical ethics, medical language, minorities, Nuremberg code, Nazi medicine, physician-patient relationship, race, Tuskegee Syphilis Study.

Everything is what it is and not another thing.
Bishop Butler, 1729 (1)

For us, the human body defines, by natural right, the space of origin and distribution of disease; a space whose lines, volumes, surfaces and routes are laid down, in accordance with a now familiar . . . anatomical atlas. But this order of the solid, visible body is only one way—in all likelihood neither the first, nor the most fundamental—in which one spatializes disease. There have been, and will be, other distributions of disease.
Michel Foucault, 1963 (2)

Words and Things

It is a truism of contemporary philosophy that Bishop Butler's seemingly incontestable claim that "everything is what it is," is wrong (1). Things, even seemingly substantial things like diseases and races, are constructed and sustained as much by conceptual frameworks as by what they are, so to speak "in themselves." In the discourse of American medicine, for example, the term "minority" that appears in the title of this paper is a construct that does not refer to minorities in any literal sense. A computer-generated survey of the use of the term "minority" in hospital and medical journals over the past five years, found not one instance in which "minority" was used to designate White Anglo-Saxon males, or Sephardic Jews, although both are clearly non-majority populations. The term was characteristically used to identity three specific minorities who collectively represent 22% of the American population: African Americans, Latinos and American Indians. A review of the medical literature establishes that this usage became prevalent in the 1980s. During that period the government declared it a "national health goal . . . to reduce disparities in the health of members of racial and ethnic minority groups"—specifically, differences between the health of the three groups in question

Professor of Philosophy, Union College, Schenectady, NY.
Address correspondence to Robert Baker, Ph.D., Department of Philosophy, Union College, Schenectady, NY 12308.

and that of “non-minority” populations, that is, everyone else (3). This use of the word “minority” seems to have originated in part as a euphemism for the term “race,” a “four-letter word” often avoided in polite medical or scientific discourse.

Generally implicit (and often explicit) in the 1980s substitution of the term “minorities” for the expression “racial or ethnic minorities” are the presuppositions that these “minorities” have poorer health status than non-minorities, that they have this status because they “receive the fewest health services” (4) and that “racial and ethnic minority populations make up a disproportionate percentage of the medically underserved” because they are vulnerable to racial and ethnic discrimination. Thus the expression “minority” in the medical literature is typically used to indicate African Americans, Latinos, and Native Americans because these three groups are presumed to be medically underserved as a result of racial and ethnic discrimination. To document these presumed inequalities in health status and in access to health care, from the mid-1980s onwards, the National Center for Health Statistics and the U.S. Department of Health’s Taskforce on Black and Minority Health began systematically to collect and publish comparative data using ethnic and racial categories (5, 6). In these comparisons, the term “minority” was typically used to designate “medically underserved ethnic and racial segments of the population who are vulnerable to discrimination” (MERV).

In February 1998 the Clinton administration, acting on the basis of over a decade of MERV comparison data, proposed a $400 million campaign to wipe out ethnic and racial differences in health status. “Nowhere are the divisions of race and ethnicity more sharply drawn than in the health of our people,” President Clinton proclaimed, citing MERV comparisons such as those showing that black children are two and a half times more likely to die in infancy than are white children. In commenting on the President’s proposal, Health and Human Services Secretary Donna Shalala remarked (7) that the race-based initiatives were needed because “we can’t wait for everybody in the country to get good health insurance”—implying that the proposed MERV-based initiative was an alternative to the administration’s failed attempt to secure universal health insurance.

As Leslie Francis has astutely observed (8), the Clinton initiative presumes a civil rights reading of the MERV comparison data, that is, it presumes that this data documents a legacy of racial discrimination in American health care, and it proposes to rectify this problem through an affirmative action initiative.

In this paper I shall argue that: (1) MERV comparisons are problematic because they obscure the dominant pattern of minority and majority convergence with respect to health-care status; (2) even if the data were reliable, the mere fact that we can construct such comparisons does not demonstrate ethnic and racial discrimination; and (3) even were there, in fact, significant ethnic and racial discrimination in American health care, the proposed “civil rights” remedy instills ethnic and racial categories into medical language and thought, and by doing so is potentially more dangerous to “minorities” than alternative approaches to health-care reform.

The Problematic Nature of MERV Data: Grueishness

Over the course of this century, the dominant trend documented by health statistics is that disparities between all ethnic and racial groups are diminishing. Thus the National Center for Health Statistics Year 2000 reports (5) that, whereas in 1900 life expectancy for whites was 47.6 years, compared to a life expectancy for blacks of 33.0 years, by 1990 life expectancy was 76.1 years for whites and 69.1 years for blacks. The data thus reflect extraordinary gains in life expectancy for blacks, whose lifespan has more than doubled since 1900; by comparison, the lifespan of whites has only increased by about 50%. Yet, since the stated objective of MERV comparisons is to document ethnic and racial health-care inequality, most MERV comparisons focus on differences in excess deaths for individuals younger than 70 years old in minority as compared to majority populations. Since the average lifespan for blacks, at 69.1 years, is under 70, while that for whites, at 76.1 years, is over 70, these analyses emphasize inequalities. What they reveal, not surprisingly, is that in comparison to whites, blacks experience an impressive-sounding 42.3% excess of deaths, Native Americans a 25% excess, the Spanish-surnamed population of Texas a 14% excess, Mexican-born Americans a 14% excess, and Cuban-born Americans a 2% excess. Yet, to reiterate, in emphasizing that blacks suffer a 42.3% excess of deaths over whites, the data obscure the dominant trend of converging lifespans in all American populations.

The aim of highlighting ethnic and racial disparities in MERV comparisons sometimes leads statisticians to create odd comparison categories,

such as the "white mothers of Chinese, Japanese, Filipino, Cuban and non-Hispanic descent" category used by the National Center for Health Statistics (5).

> As in 1980, about a quarter of the women who gave birth in 1990 failed to receive prenatal care in the first 3 months of pregnancy. Differences existed by race and Hispanic origin in the percentage of mothers who receive prenatal care early. In 1990, only about 60 percent of Hispanic (except Cuban), American Indian, and non-Hispanic mothers received care in the first trimester. Early prenatal care reached about 80 percent *among white mothers of Chinese, Japanese, Filipino, Cuban and non-Hispanic descent.* Unmarried or teenage mothers were the least likely to receive timely prenatal care. [italics added]

As the italicized terms indicate, in this particular MERV comparison mothers of Cuban and Asian American descent are construed as "white." It is noteworthy that, as members of a minority come to have the same health status and access to health care as do white mothers, they are called "white mothers," thereby heightening apparent differences between minority and "white mothers," even though, in fact, actual differences have been diminishing.

In reality, of course, Chinese Americans, Cuban Americans, German Americans, Italian Americans, Japanese Americans, Jewish Americans and Filipino Americans are distinctive groups, and Cuban, Chinese, Filipino and Japanese mothers would be startled and perhaps amused to discover that they were really white. To anyone familiar with the technical tools of analytic philosophy, this anomaly suggests "grueishness." "Grue" is the category of all things that are either observed before a certain date and green, or observed after that date and blue. This concept was invented by the American philosopher, Nelson Goodman. He constructed it to demonstrate that a logically or statistically valid category may divide the world in a capricious way that is useless for getting knowledge. In this way, the category "grue" is arbitrary and serves no explanatory function. To say that an item is "grueish" is thus arbitrary and useless. By the mid-1990s many researchers were beginning to suspect that MERV comparisons, insofar as they involve statistics lumping "mothers of Chinese, Japanese, Filipino, Cuban and non-Hispanic descent" into a single category, "white," were decidedly "grueish" artifacts of the statistician's imagination.

The Case Against MERV Comparisons

As the French philosopher Michel Foucault has observed (2), there are many ways of categorizing "health" and "disease." The deepest question raised by MERV comparisons is whether we wish to construct public health surveillance data in terms of ethnic and racial categories. Do we really wish to train every medical student, intern, resident, fellow, and attending physician to classify each and every patient in ethnic and racial terms?

The case against MERV classifications coalesced in the workshop "On the Use of Race and Ethnicity in Public Health Surveillance" sponsored by the Center for Disease Control (CDC) in January 1994. In a paper on "The Concept of Race and Health Status in America," David Williams, a sociologist from the University of Michigan, Risa Lavizzo-Mourey of the Public Health Service, and Rueben Warren of the CDC contended (9) that collecting data using racial categories not only promotes thinking in "racial stereotypes," it reinforces the outmoded presumption that "race is a valid biological category." More specifically, they pointed out that

> Although widely shared in our society, the belief that races are human populations that differ from each other primarily in terms of genetics is without scientific basis. There is more genetic variation within races than between them and racial categories do not capture biological distinctiveness . . . . Racial taxonomies are arbitrary. . . . race is more of a social category than a biological one (9).

Williams and associates argue that yet another problem with "race-based" data collection is that it often masks truly causative factors, such as geographical and socio-economic factors. Sickle cell disease, for example, is more accurately conceptualized as a geographical rather than a race-based disease.

> Although more common in blacks [sickle cell trait] appears not to result from race, but from geographical origin. Sickle cell disease occurs in white populations both within and outside the United States. The disease is most prevalent in the regions of the world where malaria was common

> (equatorial Africa, the Mediterranean, and parts of Asia) and appears to be a protective adaptation to malaria (9).

Race-based categories may also mask the effects of socio-economic status (SES):

> One of the most established patterns in social epidemiology is the relationship between SES and health. Persons with high levels of income, education, or occupational status live longer, and have lower rates of disease than their counterparts of lower social [-economic] status . . . . When racial disparities in health status are adjusted for SES, racial differences are substantially reduced and sometimes eliminated (9).

In the June 4 and July 2, 1997 issues of the *Journal of the National Cancer Institute*, key members of the President's Cancer Panel also protested that the focus on MERV comparisons masks the impact of SES. Nancy Krieger of the Harvard School of Public Health said, as reported by Reynolds (10), "that blacks, for example, have a median net worth only one-twelfth that of whites," and that "in 1991, in the lowest income quintile, the median net worth of white households was $10,257, while in black and Hispanic households it was $1.00 and $645." It also was indicated by the panelists that the absence of attention to such socioeconomic data continues to fuel erroneous notions that race is "biologic," and that we need to understand race in that way, or in purely cultural terms, and not take into account the effects of socioeconomic positions and gaps in income and wealth in this country (11).

Other authorities assembled by the President's Cancer Panel worried about a different and in many ways more important point: that the need to assemble data in racial terms introduced unscientific ethnic and racial stereotypes into the supposedly scientific literature. Solomon Katz, of the University of Pennsylvania (10), stated bluntly that "the biological category of race as applied to humans has no legitimate place in biological science." Dr. Harold Freeman (10), of the Harlem Hospital Center, President of the President's Cancer Panel, observed that "scientists who are well trained today are writing papers in the scientific literature which seem to make the assumption that race does exist, and even may make assumptions about what race is, which are not correct . . . If you make a wrong assumption and start from there your syllogism is off."

It is important to differentiate the several criticisms being voiced here. The primary criticism is that the MERV data are inherently unscientific, since there is no clear methodology for classifying persons as African American, or Latino. Is a Nigerian or a West Indian who is a naturalized American citizen an African American? One answers differently if one identifies African Americans as an American subculture, or as a racial classification. How are persons of mixed race, such as the golfer Tiger Woods, to be classified? As James Davis (11, 12), author of *Who is Black?* has argued, our present system of racial classification, in which "one drop of black blood makes you black, was invented in the 17th century to ensure that children of mixed race would remain slaves." In the modern medical context this classificatory schema means that someone is considered "black" if they either appear black to some health provider, or if they choose to identify themselves as African American on a form filled out on some occasion. This is hardly the stuff of modern genetics. And what of Latinos? Are they all the same irrespective of their country of family origin, the color of their skin, or their proficiency in English? And, to raise the more fundamental question, are researchers gathering data about cultural or subcultural identification, or about skin color? The categorization is unlikely to be anthropologically or genetically sophisticated.

Do the Data Justify Affirmative Action in the Allocation of Health-Care Funds?

Despite the problematic nature of MERV comparisons, many commentators presume that they document real ethnic and racial differences, and demonstrate the effects of institutionalized ethnic and racial biases. To quote from an article in *Pediatrics* by Dr. Aaron Shirley (13), "even when other factors are controlled for . . . the race and ethnicity of patients had a measurable, and limiting, effect on the health care they receive." President Clinton seems to share this belief, since otherwise his proposal for ethnic and racially based civil-rights-style health reform initiative would make little sense. Professor Francis offers an ingenious defense of the Clinton initiative. Francis cites studies that seem to document that blacks are less likely to receive bone marrow transplants, bypass surgery, glaucoma treatment and hip arthroplasty than are whites. Francis argues that since these studies provide strong prima facie reasons to suspect racial discrimination, we are morally obligated to presume discrimination until we find out that some non-dis-

criminatory factor explains the differences—just as we would be in cases involving employment discrimination. Hence, Francis concludes, in the absence of evidence demonstrating non-discrimination, we are obligated to support a civil-rights-style health reform, much like that proposed by the Clinton administration. (See the paper by Leslie Francis in this issue [8].)

This intriguing argument requires us to accept that, even though the purported differences in access to treatment might ultimately be attributable to socio-economic, cultural or subcultural differences that might, for example, make African Americans, Latinos, and Native Americans more distrustful of medical recommendations for aggressive technological medical interventions than people from other American subcultures, we should nonetheless treat data consistent with ethnic or racial discrimination in health-care delivery as demonstrating such discrimination. Francis is thus proposing that we should exempt the theory that the basis of differential health-care outcomes is racism, from the careful and skeptical scrutiny generally accorded causal claims. This exemption is justified, Francis argues, because the need to correct civil rights abuses is so compelling that even a prima facie case for discrimination suffices to justify a corrective policy. Francis notes, moreover, that there is precedent for such an exemption in civil rights law, as is evident from four cases of employment discrimination. In the cases she cites, the courts have held that differences in outcome alone could be treated as presumptive evidence of racial discrimination. Analogously, Francis argues, the reported ethnic and racial differences in health outcomes are sufficient to justify an affirmative action program for health care.

Francis's case for an exemption rests on an analogy between health-care delivery and employment. It thus presumes that the health provider-patient relationship is, in relevant respects, analogous to the employer-employee relationship. Yet there are significant disanalogies between these relationships. Employers pay employees, whereas it is just the opposite in health care: patients, or their insurers, pay health-care providers. Employment discrimination thus does not cost an employer money and it may well increase the paychecks of union members by decreasing the size of the labor pool. For health-care providers, however, every bone marrow transplant foregone by African Americans, every bypass surgery not undertaken, every glaucoma treatment and hip arthroplasty declined means a direct financial loss for the health-care providers involved (except under certain managed care contracts). Discrimination hits health-care providers where it hurts, at the bottom line. Money can thus function as an equalizer in health care but not in employment. Therefore, it is more reasonable to expect bias to be operative in employment than in health care.

Money, however, can only counteract bias when the objects of bias control it. This analysis thus suggests that ethnic and racial bias in health-care delivery is most likely in those areas of medicine over which patients have the least economic control. If this suggestion is correct, then Clinton-like programs, in which minority members themselves do not directly control the funds spent on their behalf, are unlikely to correct ethnic and racial biases in health care. The most effective way to eliminate such discrimination in health care would be economic empowerment of the poor (who are disproportionately African American, Latino, and Native American). For example, giving the poor vouchers enabling them to purchase health insurance from competing managed care organizations would eliminate differences in health-care purchasing power. Managed care organizations would then have every incentive to market products designed to meet the socio-cultural, ethnic, racial and class sensibilities of all Americans, whether their ethnic origin is African, Asian, Latino, Native, or White-Anglo-Saxon-Protestant.

There is a second and equally important lack of analogy between the employment data and the health-care data. Francis cites (8) several cases in which African American employees were disproportionately assigned less desirable, lower-paying jobs. It is reasonable to presume that all employees would prefer more desirable, higher-paying positions, but there is no comparable, reasonable presumption in the health-care cases cited. It is not reasonable to presume that all American subcultures desire aggressive, high-tech medical interventions equally. African, Asian, Latino and Native Americans often accept alternative medical traditions that may make them distrustful of hospital-based high-tech medicine. Thus, if one truly accepts the multiculturalism of American society, one must also accept the right of some American subcultures to be more suspicious of aggressive, high-tech medical interventions, and therefore to accept them at a lower rate, than other subcultures.

There is a pragmatic dimension to the Clinton administration's proposal and to Francis's justification of the policy. American culture developed in the context of more than three centuries of

slavery, followed by a century of legally codified racism. Insofar as the data suggest that this tradition may still be influencing American health care, it seems reasonable for Clinton officials to contend that, simply as a practical matter, funds directed at remedying this imbalance might help, and could not be harmful.

In the rest of this paper, however, I will argue that this proposal is potentially harmful because it undermines the Enlightenment-based universalism of modern medical ethics by training physicians to think of their patients in ethnic or racial terms, rather than simply as patients who have different ethnic-cultural and socio-economic backgrounds. This argument rests on a third difference between the employer-employee relationship and the health-care provider-patient relationship. Traditionally, prior to affirmative action laws, employers were held to have some moral responsibilities toward their employees, but they were not held to have moral responsibilities toward potential employees, that is, toward people who were merely job applicants. In modern medical ethics, by contrast, health-care providers have always been held to have a responsibility toward acutely ill persons during medical emergencies—even if they are not yet "patients."

In America, this responsibility was first stated in the New York Midwives Oath of 1715 (14). It was reiterated with respect to physicians by the New Jersey Medical Society, the first permanent American medical society, in its Instruments of Association of 1766 (15), which states that since physicians have "an office of benevolence and charity, we will always most readily and cheerfully, when applied to, assist gratis, by all means in our power, the distressed poor and indigent." A similar provision was retained in the American Medical Association's 1847 Code of Ethics (16), "Poverty . . . should always be recognized as presenting valid claims for gratuitous service . . . [which] should always be cheerfully and freely accorded" (16). Even today, despite the commodification of health-care services, every emergency room in every hospital in America opens its doors to anyone in need of acute care services, irrespective of their ability to pay. Employers have never undertaken a comparable moral responsibility for job applicants.

Medicine's duty to treat the acutely ill is but one aspect of a rich moral tradition of beneficent egalitarianism toward patients. This tradition also tends to protect patients against discrimination. Historically, patients have become vulnerable to socio-economic and/or ethnic and racial discrimination in medicine only insofar as they have been exempted from these traditional protections. In the next section I review some of the linguistic-conceptual mechanisms by which patients have been denied protection and made vulnerable to discrimination in previous eras of Western medicine. I will argue that the system of ethnic and racial classification required to implement any Clinton-Francis style initiative would also undermine the moral protections traditionally enjoyed by patients.

The Tradition of Beneficent Egalitarianism in Western Medical Ethics

The medical ethical tradition of beneficent egalitarianism toward patients, like Western medicine itself, was invented by the Greeks roughly two and a half millennia ago. One of the earliest and best-known formulations of ancient medical ethics is the Oath attributed to Hippocrates. Scholars have differed on the importance of the Oath. Until recently most scholars followed the lead of Ludwig Edelstein in holding that, despite the Oath's influence on posterity, it was relatively unimportant to physicians in the ancient world (17 – 19). Recent work by Owsei Tempkin (20) and Hendrick van Staden (21) has successfully challenged this view, and the Oath has been restored to its place as the single most important text in the history of Western medical ethics, from ancient times to the present day.

Two lines in the Oath's code of conduct relate directly to the question of the treatment of minorities: "I will use treatment to benefit the sick according to my ability and judgment, but never with a view to injury or wrong-doing"; "Into whatsoever houses I enter I will enter to help the sick, and I will abstain from all intentional wrong-doing and harm . . . especially from abusing the bodies of man or woman, bond or free." The Oath thus requires that all persons treated by a physician receive treatment intended for their benefit, irrespective of their status as male or female, slave or free. This core Hippocratic notion, that all sick persons are to be treated and respected equally, created an island of egalitarianism in a world that then, even more than now, was notorious for its inegalitarian treatment of ethnicity, gender, race, socio-economic class and status.

The egalitarianism of the Oath was reinforced with the rise of Rome, as Greek physicians tried to earn a living by practicing their medical skills on their Roman conquerors. To reassure his patrons that his medicines were not "poisons," the 1st-century Greek physician Scribonius Largus assured his patrons that:

> No man bound by the medical profession [i.e., the Oath] will give dangerous drugs to anyone, even to enemies of the state, although, when events demand, the same physician will fight against them as a soldier and good citizen with every means at his disposal. This is because Medicine truly promises her assistance in equal measure to all who seek her aid, and she swears never to injure anyone deliberately, for she judges men neither by their fortune nor their character. Hippocrates, the founder of our profession, handed down to our discipline an oath . . . [in which] Medicine is the science of healing, not harming (22).

In era after era, it served physicians well to reaffirm the traditional beneficent egalitarianism of the Oath. Even in the 18th century, when the Oath was supplanted by an ethics of professional morality, professional medical ethics retained this core Hippocratic value. Thus Thomas Percival (1740–1804) (23), who coined the terms "medical ethics" and "professional ethics," rephrased the Hippocratic ideal of beneficent egalitarianism in the new language of "medical ethics" when he asserted that "Every case, committed to the charge of a physician or surgeon, should be treated with attention, steadiness and humanity" (23). This line is a line echoed, almost word-forword, in the foundational document of American medical ethics, the 1847 American Medical Association's Code of Ethics, (Chapter I, Article I, Section II [16]).

Conceptual-Linguistic Marking and Discriminatory Practice

Minorities are clearly protected by the beneficent egalitarianism that lies at the core of the Western medical ethical tradition. One might presume, therefore, that at least at the level of ethical principle, the history of minorities in Western medicine is a history of beneficent egalitarianism, and that the conduct of medical practitioners could thus serve as a model and a rebuke to the rest of society. Would that history were so straightforward. One might think that, to quote Bishop Butler (1), "Everything is what it is and not another thing," and so all sick people would be treated as sick people, and thus protected equally by the traditional ethic of beneficent egalitarianism. Historically, however, people have invented clever ways of distinguishing between apparently identical things, and have used these distinctions to discriminate. One way in which they do this, linguistically, is by "marking" nouns to differentiate subsets from the class of objects or persons normally picked out by the noun. For example, a "woman driver" is not merely a driver who happens to be a woman, as is evident from the fact that we have no correlative expression "man driver"; rather, the expression marks women as different from, and presumably inferior to, the normal driver, who is presumed to be a man. Other similar uses of "woman" mark out women as unusual, different from what the speaker would normally expect: "woman doctor," "woman golfer," "woman surgeon," and so forth. In each case, the marked form designates a non-normal and presumptively inferior subclass. The mechanisms for marking may also attach to suffixes, as it does in the term "poetess," for example. Here again, the marked form implies both differentiation and inferiority (21).

One notorious use of noun marking occurred in 1938. Heinrich Rothmund, a Swiss police official, feared that the Swiss would be subjected to *Überfremdung* (ethnic contamination) from the flood of Jews fleeing Nazi Germany, because all holders of German passports could enter Switzerland without a visa. To remedy this "problem" Rothmund requested that the German government mark the passports of all Jewish citizens with a "J" to distinguish them from other German citizens. The Germans agreed, provided that the Swiss government reciprocate. Soon both governments began to mark the passports of their Jewish citizens with a "J", thereby transforming citizens who happened to be Jews into "Jewish citizens." Linguistic marking soon translated into discriminatory practice and "citizens" with marked forms soon found that they had lost the right to cross the German-Swiss border (25).

Another linguistic distinction with morally disturbing consequences was prevalent in the medical language used in Britain two hundred years earlier. Eighteenth-century Britain was the birthplace of the modern hospital, which was originally thought of as a charitable institution that specialized in aiding sick persons. Perhaps not unnaturally, therefore, sick persons treated in hospitals were always referred to as "sick poor," never as "patients"—a term that was reserved for upper- and middle-class private practice patrons. Although these linguistic distinctions seem trivial, they had substantial consequences. Patients were accorded confidentiality and all the other traditional protections afforded by a beneficently egalitarian Western medical ethical tradition. (This was not a particularly altruistic policy, since the socio-economic status of upper-class patrons was

typically higher than that of their physicians.) By contrast, the sick poor were treated as being in all ways less deserving, and were denied confidentiality and other traditional ethical protections. The linguistic distinction between "the sick poor" and "patients" thus enabled physicians and surgeons to maintain a lower standard of conduct toward the "sick poor" while still embracing the tradition of beneficent egalitarianism toward their "patients" (26).

Philosophers are often accused of paying too much attention to mere "words." Yet words designate concepts and concepts structure our world. What, after all, is a hospital but a concept made concrete by brick, mortar, and social practices? In the 18th century, the conceptual division between "patient" and "sick poor" was made concrete in a double standard of treatment. To tear down this double standard, 18th-century medical reformers, like Thomas Percival, had to coin a new language in which the term "patient" was extended to embrace everyone in need of care, "the sick poor" as well as affluent "private patients." In 1794, Percival penned what is perhaps the most radical line in the history of Western medical ethics when he wrote that "the moral rules of conduct, prescribed toward hospital patients should be fully adopted in private practice" (Medical Jurisprudence, Section Two, Article I [27], repeated in Medical Ethics, Chapter Two, Article I [23]). This line precedes the more commonly quoted sentence, "Every case, committed to the charge of a physician or surgeon, should be treated with attention, steadiness and humanity." In these lines, Percival tore down the walls separating "the sick poor" from "patrons," deghettoizing standards of medical practice by insisting that a single term "patient," a single ethic, beneficent egalitarianism, and a single standard of conduct apply to all persons, rich or poor alike (28). In the 19th century, especially in America, these egalitarian precepts became the received canon of medical ethics, adopted in principle, if not always in practice (16).

The Ghettoization of Medical Language in Germany in the 1930s and 1940s

Medical ethics was strikingly reghettoized by the German medical profession during the 1930s and 1940s. Again, linguistic change, conceptual ghettoization so to speak, served as a precursor to physical ghettoization, as ideas of eugenic purity (*Rassenhygiene*) were made concrete as concentration camps and crematoria. As Michael Burleigh, Robert Proctor and others have argued persuasively, the comforting view that German physicians were largely innocent in the affairs of the Third Reich, or that they were corrupted into complicity, or that they were coerced into cooperation with the Nazis, is inconsistent with the known evidence (29 – 31). Physicians themselves created many of the concepts later adopted by the Nazis, and many physicians were drawn to the Nazi party in its early days because it embraced eugenicist-naturalist-collectivist biological models that they and their teachers had invented. Many German health reformers held that traditional individualist medicine should be supplanted by a "people's health movement" (a movement from *Fürsorge* to *Volksfürsorge*). In this new people's health movement, the older medical obligation to use treatment to benefit the patient was to be transformed into the obligation to serve public health (*Gesundheitspflicht*), a duty understood as preserving racial-cultural community (*Volksgemeinschaft*). The duty to preserve the public health required teaching hygiene and sanitation, developing a communal regimen of fresh air, exercise, and wholesome natural food, and campaigning against habits, such as the use of tobacco, that debilitated public health. Similarly, the duty to preserve racial community required protecting the community against those who posed a eugenic threat to the community (*Gemeinschaftfremde*), and those who could no longer live a life that could meaningfully contribute to the community *(lebensunwerten Lebens*). Racial hygiene involved genetic quarantine through sterilization and the physical elimination of "life unworthy of life." The hygienic killing began with the mentally and physically handicapped, and culminated in the attempt to "purify society" of Jews, Gypsies, and homosexuals.

At the end of World War II, some of the physicians involved in these efforts were placed on trial at Nuremberg. Dr. Karl Brandt, Hitler's personal physician and a key figure in the eugenic extermination program, was asked whether his conduct could be reconciled with the Hippocratic Oath, that is, with the Western tradition of beneficent egalitarianism. Brandt replied that had Hippocrates lived in Germany in the 1930s, he would have revised his Oath. In fact, that is precisely what the German medical profession did: they revised the traditional medical ethics of beneficent egalitarianism by differentiating, first at the level of language and concept, and then at the level of institutional and personal activity, between patients, and *Gemeinschaftfremde* and *lebensunwerten Lebens*. Physical ghettoization lagged behind conceptual ghettoization by several decades. Eventually, however, differentiating

concepts were made concrete in concentration camps and crematoria (32).

The Presumption of Nazi Exceptionalism: Some Historical Reflections

The German experience under the Nazis is almost always dismissed as so extreme, so unlike anything that preceded it, that it lacks precedential value. In one respect, however, it is remarkably similar to the pattern we observed in 18th-century Britain. For while there was no holocaust in 18th-century Britain, there was pervasive discrimination against the "sick poor." British physicians reconciled their discriminatory conduct with the traditional medical morality of beneficent egalitarianism by linguistically and conceptually differentiating between patients proper and those whom they treated differently. In Britain, as in Germany, institutional and physical discrimination accompanied linguistic-conceptual differentiation. This said, many would suggest that the disanalogies between the British and the Nazis seem so vast that these few similarities have no precedential value. Yet the belief in Nazi exceptionalism also has a disturbing history. At the Nuremberg trial, in an effort to justify their verdict, the Tribunal issued its now-famous ten principles of morally permissible experimentation on human subjects (29). These principles asserted, for the first time in Western medicine, that the primary requisite of ethically permissible experimentation on humans is the informed voluntary consent of the subject. After the trial ended, there was an attempt to institute the Nuremberg code world-wide. American physicians, however, rejected the code. To justify this, they cited Nazi exceptionalism. "These codes [are] necessary for barbarians but [not] fine upstanding people" remarked one physician ([33], p. 86). Historian David Rothman observed that "The events . . . at Nuremberg were not perceived by researchers . . . to be directly relevant to the American scene . . . the violations had been the work of Nazis, not doctors; the guilty parties were Hitler's henchmen, not scientists . . . . Madness not medicine was implicated at Nuremberg . . . the prevailing view was that [the defendants] were Nazis first and last; by definition nothing they did, and no code drawn up in response to them, was relevant to the United States" (34).

Post-Nuremberg Discrimination Against Research Subjects in the United States

In the early 1960s, perhaps the strongest opponent of the Nuremberg principles was Dr. Henry Beecher of Harvard. In particular, Beecher was opposed to imposing the consent requirement on patients. In therapeutic contexts, he argued, obtaining informed consent was "folly . . . . Difficult . . . to the point of impossible." The patient-subject was best protected by the "character, wisdom, experience, honesty, imaginativeness and sense of responsibility of the investigator" (33). By the mid-1960s, however, Beecher came to the horrifying realization that the Nazi conduct was not as exceptional as he had initially thought. Researchers in American were abusing their responsibilities to those patients whom they were recruiting as subjects. In a process memorably portrayed by David Rothman, Beecher "blew the whistle" on American medical researchers in an article published in the *New England Journal of Medicine* (35). The article analyzed the treatment of human subjects reported in twenty-two research papers published in such leading medical journals as *Circulation, Journal of the American Medical Association* (JAMA), *Journal of Clinical Investigation*, and the *New England Journal of Medicine* between 1948 and 1965. All the papers reported practices in violation of the Nuremberg code. Moreover, if one reviews the papers cited by Beecher, the pattern of conceptual-linguistic differentiation that we observed in the 18th century, and in the Germany of the 1930s and 1940s was sustained. The studies not only target their research at socio-economically, ethnically, racially, and other gender-vulnerable groups—recruiting subjects who were either African American, or Jewish American, or poor, or uneducated, or post-reproductive females, or prisoners, or the mentally handicapped—they refer to their subjects in a language that marked them as different from ordinary patients.

Linguistic Marking in the Tuskegee Syphilis Study

The relationship between linguistic differentiation and unethical treatment is evident, for example, in the most notorious study conducted in the pre-regulatory era, the Tuskegee Syphilis Study (36). The origins of the study trace back to a well-intentioned effort in the 1920s when the United States Public Health Service (USPHS) joined forces with the Julius Rosenwald Foundation of Philadelphia in a project to eradicate syphilis in medically underserved populations. Using race-based categories, the USPHS, acting in cooperation with the Tuskegee Institute, surveyed Macon County, Alabama, and found that 36% of the "Negro" male population had syphilis.

The foundation then planned and began to fund a demonstration project in which 3,694 "Negro" men were to receive treatment with neosalvarsan—the treatment of choice in the pre-antibiotic era. In 1929 the stock market crashed, and mid-project the Foundation found itself without funds. The USPHS also lacked the funds needed to continue providing treatment; nonetheless, it continued race-based surveillance and, in 1931, resurveyed the county and located 399 "Negro" males with untreated syphilis, who were also, as it happened, too poor to pay for medical treatment. This discovery led the USPHS to launch a longitudinal study of "300 syphilitic Negro males who had never received treatment" (37). In order to track this group, the subjects were invited to receive "treatment" for "bad blood" that was "free of charge," although, in fact, they did not receive treatment but were monitored through the use of spinal taps. These observations continued despite the availability of cheap and effective antibiotic therapy in the post-war period. The subjects were never informed that they suffered from syphilis. The study was terminated in 1972 after Peter Buxton, a whistleblower in the CDC, brought the story to the attention of an Associate Press reporter.

Tuskegee and Proposals for Ethnic and Racial Allocation of Health Resources: Some Analogies

Tuskegee, in conjunction with the other research scandals, created a national outcry. A number of investigative committees were formed. One of these, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, adopted a modified version of the Nuremberg code that was to be enforced by institutional review boards. (This form of patient protection was first proposed by Percival in 1794.) Since the initiation of these "new" forms of ethical constraint, the blatant research abuses of the pre-regulation era appear to have been eliminated. We can once more feel complacent about our own decency and dismiss the past as prologue, rather than regarding it as precedent.

Today, confident in their purity of purpose and good intentions, government officials again propose systematically to distinguish African Americans, Hispanic Americans, and Native Americans, from all other Americans in matters of health care. Like the Rosenwald Foundation in the 1920s, the Clinton Administration is offering new money to address pressing health-care needs; like the USPHS in the 1920s, the Department of Health and Human Services is proposing to allocate these funds to medically underserved, racially defined populations. Just as in the 1920s, there will be a temporal limit to the new money that will be expended. Yet, as in the 1920s, the racially constructed surveillance of patients and populations is likely to continue, even after funding sources dry up. No one can tell whether these racially constructed conceptions, like those constructed by the USPHS in the 1920s, will provide a basis for new forms of discrimination. One can be certain, however, that linguistic-conceptual differentiation has served as a springboard for discrimination in the past. Thus, attractive though it may be to target funds at medically underserved, ethnically or racially defined populations, if the past provides a precedent, those populations would be better served were these funds allocated simply in terms of medical need. To paraphrase the most venerable lines in Western medical ethics, funds should be allocated "to benefit the sick . . . whether man or woman, bond or free," black or white, minority or majority.

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