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THE FLEXNER REPORT: STANDARDIZING MEDICAL STUDENTS THROUGH REGION-, GENDER-, AND RACE-BASED HIERARCHIES

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In 1910, Abraham Flexner, a leading U.S. educational scholar, took on a task issued by the Carnegie Foundation to assess the curricular components of medical schools in the United States and Canada.[1] His groundbreaking report transformed the practice of educating doctors, making institutions more standardized and uniform in their aim to educate the next generations of physicians.[2] It is through his work that medical doctors became well-respected professionals with extensive and complex training.

In streamlining and raising the standards of medical education, Flexner's report articulated an ideal learning situation for the transference of medical knowledge which ultimately constructs an ideal student so marked by his regional, race, and gendered attributes. Northern wealthy white men implicitly became the prototypical student as previous practices that served a more diverse student body were shed. According to Flexner, "professional patriotism," a sense amongst doctors that they owe the profession their best work and practice, is best cultivated with a more homogenous pool of doctors who are deserving of the subsequent societal privileges they should be

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[1] *See* ABRAHAM FLEXNER, MEDICAL EDUCATION IN THE UNITED STATES AND CANADA: A REPORT TO THE CARNEGIE FOUNDATION FOR THE ADVANCEMENT OF TEACHING (1910).

[2] *See* Thomas P. Duffy, *The Flexner Report–100 Years Later*, 84 YALE J. BIOLOGY & MED. 269, 269 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3178858/pdf/yjbm_84_3_269.pdf [https://perma.cc/Z5E5-3XA3].

afforded.[3] The Flexner Report is an essential document that created the context for medical education as it is understood today, effectively constructing the conditions of optimal medical education, which included a privileging of visual information and the subsequent need for a particular type of student. Critical Race Theory of the health sciences provides an important lens of analysis of this moment in medical history. By looking at the ways race influenced a de facto medical law that governed medical education, one can begin to see the difficulties of trying to change these systems of power in this contemporary moment. The latent white supremacy embedded within Flexner's report continues to color medicine more than 100 years later.

Abraham Flexner travelled to all 150 medical schools within the United States and Canada between 1908 and 1910.[4] He assessed the conditions at these institutions and made recommendations for a new curriculum.[5] His findings addressed both the current and desirable state of medical education and most significantly called for streamlining curricula and limiting the number of institutions that would be allowed to grant medical degrees.[6] By his selective estimate, only thirty-one schools were deemed worthy of survival, and those still needed a dramatic overhaul to become practical degree-granting institutions.[7]

Born in Louisville, Kentucky in 1866, Abraham Flexner came of age in a rapidly changing South.[8] As a student at John Hopkins University, he set his sights on a career in education and became increasingly interested in pedagogy in different academic environments.[9] Upon completing his undergraduate degree, he studied at Harvard and in Berlin, both experiences that furthered his interest in how education was imparted to young minds.[10] His first book, *The American College,* took a critical look at the North American higher education system and came to the attention of members of the Carnegie Foundation.[11] The foundation, under advisement from the American Medical Association, recruited Flexner as an impartial evaluator to review American medical colleges in the way that he had examined undergraduate institutions.[12]

Although earlier attempts to improve the state of American medical schools were conducted, many failed.[13] Schools' economic interests often superseded their interest in addressing curricular needs.[14] Of particular concern for medical school reformers

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[3] *See* FLEXNER, *supra* note 1, at 17 ("It appears, then, that the country needs fewer and better doctors; and that the way to get them better is to produce fewer.").

[4] *See* Henry S. Pritchett, *Introduction* to ABRAHAM FLEXNER, MEDICAL EDUCATION IN THE UNITED STATES AND CANADA: A REPORT TO THE CARNEGIE FOUNDATION FOR THE ADVANCEMENT OF TEACHING, at viii (1910).

[5] *See id.* at x–xi.

[6] *See id.*

[7] *See* FLEXNER, *supra* note 1, at 185-326; Martin Kaufman, American Medical Education: The Formative Years, 1765–1910 169 (1976).

[8] Thomas Neville Bonner, Iconoclast: Abraham Flexner and a Life in Learning 1–2 (2002).

[9] *See* NEIL A GRAUER, LEADING THE WAY: A HISTORY OF JOHNS HOPKINS MEDICINE 41 (2012). Abraham Flexner was a protégé of Daniel Coit Gilman, one of the founders of John Hopkins Hospital. *Id.* Flexner's older brother Simon was a medical doctor trained at Hopkins with some financial help from Abraham. *Id.*

[10] Michael Spangler, *Abraham Flexner Papers*, MANUSCRIPT DIVISION, LIBRARY OF CONGRESS, http://lcweb2.loc.gov/service/mss/eadxmlmss/eadpdfmss/2003/ms003042.pdf [https://perma.cc/RUS2-6LS9].

[11] *See* ABRAHAM FLEXNER, THE AMERICAN COLLEGE: A CRITICISM (1908); PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 118 (1982).

[12] *See* WILLIAM G. ROTHSTEIN, AMERICAN MEDICAL SCHOOLS AND THE PRACTICE OF MEDICINE: A HISTORY 144 (1987).

[13] *See id.* at 143.

[14] *See id.* at 144.

was the practice of curtailing the academic year to accommodate students' desires for shorter semesters.[15] Medical schools keen on generating income accepted many students and turned out many doctors, apparently flooding the market with more doctors than could be easily maintained by demand. However, this oversaturation of the market was only true insofar as the doctors in question wanted to work in urban environments. Rural communities struggled to attract and retain doctors during this time period and continued to rely largely on healing practices that were plant-based and required less invasive methods.[16] The question of access, however, was secondary to concerns of quality amongst newly-minted doctors entering the field.

Despite these cost saving measures, American medical schools were under extreme financial pressure to change their practices.[17] Many medical schools were struggling to remain in operation.[18] There were too many medical schools and too few students to maintain a level of enrollment for most to stay afloat.[19] Many schools had low standards that included a lack of quality admission requirements and a lack of successfully-matriculated students.[20] These factors contributed to the shifting medical education landscape before Flexner was able to conduct his study or publish his report. These realities supported the pruning of medical schools, such that many of the suggestions that Flexner made were already in motion before his work was finished.[21]

As the Industrial Revolution picked up steam, the public became more interested in established institutionalized medicine.[22] Schools had trouble paying faculty and staff, let alone supplying classrooms with the latest technology, something that both students and patients began to expect.[23] No longer was an apprenticeship model of medical education sufficient for doctor training. Medical schools connected to hospitals became highly favored.[24] Historian Charles Rosenberg states that by the beginning of the twentieth century, "[t]o many physicians and increasing numbers of laymen, the hospital had become the only appropriate place to practice medicine of the highest quality," effectively devaluing other forms of medicine that were not directly linked to it.[25] These circumstances helped to bolster the validity and attention that Flexner's report received. The American Medical Association supported the report not solely because of the ideas therein, but largely to distinguish itself from other medical sects like homeopathic and eclectic traditions at the time by being a part of vanguard reform.[26]

Flexner had no prior engagement with medical schools but took to his task with a meticulous fervor. *Medical Education in the United States and Canada; a report to the Carnegie Foundation for the Advancement of Teaching*, or The Flexner Report as his findings came to be known, set in motion a revolution in medical education marked by

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[15] JOHN DUFFY, FROM HUMORS TO MEDICAL SCIENCE: A HISTORY OF AMERICAN MEDICINE 137 (1993).

[16] FLEXNER, *supra* note 1, at 15–16.

[17] *See* KAUFMAN, *supra* note 7, at 109–24.

[18] *See id.*

[19] *See id.*

[20] *See id.*

[21] FLEXNER, *supra* note 1; *see also* KAUFMAN, *supra* note 7, at 171–79; WILLIAM G. ROTHSTEIN, *supra* note 12, at 119–20 (1987).

[22] George Rosen, The Structure of American Medical Practice, 1875–1941 50–51 (1983).

[23] *Id.* at 59–61.

[24] *Id.* at 64.

[25] CHARLES E ROSENBERG, THE CARE OF STRANGERS: THE RISE OF AMERICA'S HOSPITAL SYSTEM 9 (1987).

[26] Robert P. Hudson, *Abraham Flexner in Historical Perspective*, *in* BEYOND FLEXNER: MEDICAL EDUCATION IN THE TWENTIETH CENTURY 15 (Norman Gevitz & Barbara Barzansky eds., 1992).

school closings and consolidations.[27] The report was a major impetus propelling the consolidation of the medical schools in Atlanta, Georgia into Emory School of Medicine.[28] In Atlanta, an 1898 decision by the administrations of Atlanta Medical College and Southern Medical College led to the consolidation of the schools into the Atlanta College of Physicians and Surgeons; the consolidation occurred prior to Flexner's release but was a result of the financial tensions that were also Flexner's motivation.[29] In 1905, the dean resigned to start his own school.[30] The rivalry between these two schools was intense but the Flexner Report, along with pressure from the American Medical Association, led to their consolidation into what became Emory School of Medicine.[31] Flexner's recommendations marked the standardization of the practice of medicine, as we understand it today, and set the bar for what constitutes a medical education. The goal of his research was to create a normative model of training that attempted to replicate the program at John Hopkins University at all North American medical schools.[32]

I. NORTHERN MEDICINE FOR AILING SOUTHERN SCHOOLS

Flexner begins his report by chronicling the rise of the formal medical education system that initially augmented the more desired and common practice of medical apprenticeship.[33] He notes that the rise in the number of medical schools across the country had a negative effect on both the quality of education that future doctors were receiving and the subsequent care that the patient was provided.[34] The growing cost of providing a top-rate medical education further exacerbated the problem of too many medical schools as it became increasingly expensive for schools to survive. Schools started closing their doors on their own accord because it was just too costly to keep them open.[35] This unfortunate turn for medical schools proved fortuitous for Flexner; his connection with the philanthropic Carnegie Foundation most likely helped him gain access to institutions that hoped his presence foreshadowed a future financial windfall.[36] The report takes an exhaustive look at each medical school in each state and makes recommendations for those that should be supported and those that need not be saved.

Flexner's attention to fiscal concerns is evident through the entire report. He demands universities give more support to their medical programs, calling for them to agree to financial responsibility for medical schools.[37] He warns against the production of "cheaply made doctors" who overwhelm in their numbers and yet are lacking in skill.[38] He assures his readers that there is no need for low standards or poor training

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[27] *See* KAUFMAN, *supra* note 7, at 173.

[28] *See* John Daniel Martin & Garland D. Perdue, The History of Surgery at Emory University School of Medicine 15 (1979).

[29] *See id.* at 4.

[30] *See id.* at 11–12.

[31] *See id.* at 2–22.

[32] *See* LLOYD C. TAYLOR, THE MEDICAL PROFESSION AND SOCIAL REFORM, 1885–1945 45–46 (1974).

[33] FLEXNER, *supra* note 1, at 3–6; *see also* Martin Kaufman, *American Medical Education*, *in* THE EDUCATION OF AMERICAN PHYSICIANS: HISTORICAL ESSAYS 7–8 (Ronald L. Numbers ed., 1980).

[34] FLEXNER, *supra* note 1, at 6.

[35] FLEXNER, *supra* note 1, at 11.

[36] *See* Kaufman, *supra* note 33, at 20–21; ROSEN, *supra* note 22, at 63–66; STARR, *supra* note 11, at 119.

[37] *See* FLEXNER, *supra* note 1, at 13.

[38] *See id.* at 14.

just to produce more doctors.[39] He arrives at the ratio of one doctor for every 1,500 people in the population and contends that, with an intentional paring back of schools and an increase of standards, the number of doctors produced will exceed even this minimum requirement.[40] Flexner addresses the South in particular on this point, anticipating the concern from the less affluent part of the country. He writes:

> . . . 1300 southern doctors to compete in a field in which one-third of the number will find the making of a decent living already difficult. Clearly the south has no cause to be apprehensive inconsequence of a reduced output of higher quality. Its requirements in the matter of a fresh supply are not such as to make it necessary to pitch their training excessively low.[41]

In short, Flexner suggests the country needed "fewer and better doctors."[42] Throughout the remainder of the report, *fewer and better* comes to represent white men of means, privilege, and Northern sensibilities.

In chapter two of the report, Flexner explains the need to safeguard schools from "crude . . . untrained boys" who are "casual strollers from the highway."[43] The tools needed for proper medical education required vigilance in attention that could not be assured with some of the practices at medical schools at the time. In particular, Flexner questions the practice of arranging the dates of the academic calendar in accordance with seeding and harvest time.[44] By calling for medical schools to liberate themselves from accommodating students with rural backgrounds, he effectively calls for a more privileged class of students to enter the profession. Other aspects of medical education that accommodated rural and local community interests were abandoned as well.[45] Flexner concludes that only 1,300 doctors were needed for Southern states, and current enrollment far exceeded the demand.[46] In reforming medical education, Flexner also calls for a new student that was not tied to the farm. He quips, "The best material for making a few hundred southern doctors need not be torn from the plo[w]."[47] *Southern* became synonymous with agrarian and agrarian with a depreciated caliber of men, wholly unlike those from urban areas. Flexner's equation of quality with urbanized sensibilities reflected and reinforced stereotypes about Southerners as rural, backwards, and unintelligent.

However, Flexner's estimates only applied to the number of doctors needed to effectively serve the white population of the South. Flexner notes that six schools were sufficient to provide the number of qualified doctors for the region.[48] These six schools did not include any of the Black medical schools Flexner thought worthy of retention,[49] as they were expressly responsible for the education of Black physicians who would work with Black patients. This omission reflected the perceived divisions between Black and white people in medicine. For Meharry and Howard Medical

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[39] *See id.*
[40] *See id.* at 16–17.
[41] *Id.* at 17.
[42] *Id.*
[43] *Id.* at 22.
[44] *See id.*
[45] *See* Kaufman, *supra* note 33, at 21; ROTHSTEIN, *supra* note 12, at 144.
[46] FLEXNER, *supra* note 1, at 17.
[47] *Id.* at 40.
[48] *See id.* at 148.
[49] *See id.* at 148 n.2.

Schools to be relegated to a separate discussion was representative of the racial divisions of a Jim Crow South.

Flexner reasons that doctors needed to know an abundant amount of information in order to practice effectively; little time could be spared teaching the basics and/or truncating the schedule to serve rural students.[50] He proposes that the entrance standards be raised and that entering students have a working knowledge of chemistry, physics, and biology on which to build.[51] These core subjects, with the addition of mathematics and writing, remain the core requirements for medical school admission to this day.[52] Meeting these requirements necessitated a college background, and thus all those pursuing the medical profession without this expensive requisite training were effectively excluded. Flexner cites the Atlanta School of Medicine as a particularly flagrant example of the problem of low requirements, with seventy-three percent of the 1908 entering class granted admission based on having equivalent requirements that were never verified.[53] Flexner also mentions Grady Memorial Hospital in Atlanta, which, despite having room for six students per bedside clinic session, only had two students in attendance.[54] He maintains a stringent critique of Southern medical education throughout the report.

Flexner's Northern sensibilities become evident through his harsh critiques of the Southern educational system. His expressed hope is that the South would make more of an investment into secondary education as opposed to higher education.[55] Many students within the graduate system were tremendously underprepared, effectively lowering the standard to which they were measured.[56] A shift needed to be made. But in articulating the need for Southern reform, Flexner privileges the Northern model, effectively mandating the obfuscation of regional specificity in the reconstruction of the Southern medical colleges and their students. What could have been an opportunity to incorporate the unique climate, flora, and fauna of the South into medical education was squelched. A one-size-fits-all approach was applied such that medical education in its uniformity could only accommodate one type of student.

Flexner articulates the need for an intermediate step between high school and medical school by noting the immaturity of the high school student and stressing the imperative for lab experience and scientific knowledge prior to attending medical training.[57] His insistence on college before medical school reflects a departure from the medical school trajectories of other nations, where some high school was sufficient for the start of medical training.[58] Flexner's previous work evaluating colleges pushed his desire to see it as a necessary educational pit stop for future physicians.

This call for college particularly affected Southern medical schools that had lax prerequisites for admission. At the time of Flexner's report, only sixteen of the 155 medical schools required a college diploma for admittance, and an additional six schools required at least one year of a college education.[59] Flexner writes:

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[50] *See id.* at 42–43.

[51] *See id.* at 24–26.

[52] *See* Edward C. Atwater, *Clinical Education Since Flexner or Whatever Became of William Osler?*, *in* BEYOND FLEXNER: MEDICAL EDUCATION IN THE TWENTIETH CENTURY, *supra* note 26, at 43.

[53] *See* FLEXNER, *supra* note 1, at 36.

[54] *See id.*

[55] *See id.* at 40–41.

[56] *See id.* at 6, 9, 41.

[57] *See id.* at 24–26.

[58] *See generally* Atwater, *supra* note 52, at 45–47 (discussing different forms of undergraduate clinical education before medical school).

[59] *See* FLEXNER, *supra* note 1, at 28.

> Southern Schools . . . after specifying an impressive series of acceptable credentials ranging once more from university degrees downward, announce their satisfaction with a "grammar school followed by two years of high school," or in default thereof a general assurance of adequate "scholastic attainments" by a state, city, or county superintendent, or some other person connected with education or purporting to be such; but the lack of such credentials is not very serious, for the student is admitted without them, with leave to procure them later.[60]

Flexner highlights the Atlanta School of Medicine as a particularly egregious offender, citing that seventy-three percent of the 1909 entering class were admitted on equivalent status or lacked the requirements for admission all together.[61] As noted above, Grady Memorial Hospital is also chastised because their students did not regularly attend bedside clinic, a practice of learning pateint protocols by listening as a doctor interviews patients.[62] Seventy percent of the 1909 class of The Atlanta College of Physicians and Surgeons dropped, conditioned (must meet additional requirements), or failed by the school year's end.[63] Flexner is particularly critical of Charlotte, North Carolina's medical school, recounting the words of a senior administrator who said, "[I]t is idle to talk of real laboratory work for students so ignorant and clumsy. Many of them, gotten through advertising, would make better farmers. There's no use in having apparatus for experimental physiology—the men couldn't use it; they're all thumbs."[64]

Flexner's impatience with the South is acute. He asks, "How much longer will the southern people, generously spending themselves in the effort to create high school systems, continue to handicap their development by legally allowing medical education to rest on an ante-bellum basis?"[65] He continues, "The weak southern schools apologize for their wretchedness by alleging the short comings of the student body."[66] Flexner's displeasure with the South is not simply relegated to the region; it is also complicated by class as he continually references the need to protect the profession from farm and poor boys that, in his view, have limited aptitude for medicine and limited resources with which to pay for school.[67] Flexner objects to defenders of low standards and equivalences so that *poor boys* are not excluded from the profession. He counters with the logic that admitting unqualified poor boys comes at the cost of the health and well being of those on the receiving end of their care.[68] His analysis anticipates complaints that rural and Southern towns will suffer without doctors because medical students of means will unlikely desire small town life. Flexner dismisses this concern, citing the breadth of distribution of John Hopkins graduates, the best in the country, to thirty-four states and territories (though the distribution in rural areas is not addressed).[69]

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[60] *Id.* at 36.
[61] *See id.*
[62] *See id.*
[63] *See id.* at 37.
[64] *Id.* at 36–37.
[65] *Id.* at 41.
[66] *Id.*
[67] *See id.* at 42–44.
[68] *See id.* Flexner applies a logic similar to opponents of affirmative action, stating that efforts to level the playing field in regards to equal access to education is premised on lowering the bar for some at the expense of others. *See id.*
[69] *See id.* at 45.

By writing in favor of students who already have access and financial means, Flexner helps to solidify the status of doctors in American life. His privileging of students who already had the economic resources to attend school helped redirect school funds to infrastructure and curriculum. Medical schools no longer needed to offer money in the form of scholarships to needy students, but could consolidate their power by following recommendations that call for a more technical curriculum that requires extensive laboratory knowledge. By asking schools to spend more on equipment and training, Flexner advocates for schools to divert funds from other costly endeavors, particularly student scholarships.[70] Flexner explicitly calls for an end to the heterogeneity among the medical student body in favor of a more uniform student who will become a standardized practitioner.[71] Within this new framework, Flexner does concede a different standard for the South in the form of a slightly relaxed equipment list for southern schools that grapple with far less economic resources than other parts of the country.[72] Despite this concession, students within Southern schools are expected to conform to new ideas about the ideal student, who is not from the farm and has significant funds to contribute to his own medical education.

Flexner asserts that medical education should be divided into two parts: laboratory sciences in the first two years and clinical work in the last two.[73] Students will learn first and apply second, though he admits that these divisions are somewhat arbitrary.[74] Faculty members' knowledge should be sharpened through research so that they are aware of the latest happenings in their respective fields and so that students receive instruction that is reflective of up-to-date practices. He argues for full-time faculty, effectively preventing the development of community-based medical learning that accompanied part time faculty instructors who also worked in clinics and networks apart from the hospital.[75] Although students are taught by instructors who are specialists, Flexner believes the coming together of these different sciences in the mind of the young physician will produce the best kind of practitioner.[76] He endeavors to maintain a spirit of enthusiasm within the practice of medicine. He imagines that students should be organically drawn to the profession, not seduced by promotional materials that lures them away from other interests with the promise of a high salary upon graduation.[77] He wants students taught by instructors who buoy their sense of connection to the practice and warns against the compartmentalization of subjects that do not ultimately support the goal of training a proper physician.

Flexner talks at length about the curriculum, discerning the different components and their varying weight in terms of overall instruction for the student.[78] Flexner examines the standard four years of instruction and the enormous amount of material

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[70] *See* ROSEN, *supra* note 22, at 66–67. *But see* Flexner, *supra* note 1, at 43 ("Doubtless in the near future, the problem will be still further simplified in the interest of the better training by increased scholarship and other endowments . . . .")

[71] FLEXNER, *supra* note 1, at 30 ("To get at the real admission standard, then, of these medical schools, one must make straight for the 'equivalent.'").

[72] *See id.* at 85–89.

[73] *See id.* at 57.

[74] *See id.*

[75] *See id.* at 137–38; *see also* ROTHSTEIN, *supra* note 12, at 167–68.

[76] *See* FLEXNER, *supra* note 1, at 57–69.

[77] *See id.* at 45 ("Of course there are compensations. But the point is that a large financial inducement is not indispensable, provided a man is doing what he likes. In most sections the country doctor has better worldly prospects. The fact stands out that it is not income but taste that primarily attracts men into scholarly or professional life.").

[78] *See id.* at 71–125.

that must be covered.[79] He critiques the average four thousand hours of instruction, surmising that many of these hours could be eliminated by appropriately preparing students prior to their professional medical education.[80] This shift in the instruction of medical education permits more time for *doing* on the part of students, meaning more clinical and laboratory instruction as opposed to memorization. Once again, Southern medical schools bear the brunt of Flexner's critique, called 'mercenary' due to their failure to provide the bare necessities for laboratory instruction.[81] Very few resources, limited access to autopsies, even outdated textbooks place Southern medical schools at the bottom of Flexner's list. The Atlanta College of Physicians and Surgeons is singled out for having too few microscopes.[82] The Atlanta Medical College did not have access to a single post-mortem autopsy for the entire year of 1909.[83] Flexner cautions that students who do not have access to clinical rotation in the third and fourth year are at a severe disadvantage.[84] At the time of his report, many schools worked independently of hospitals.[85] Teaching hospitals became a requirement for medical instruction through Flexner's report.

According to Flexner's new system, a medical student should have some basic competencies. He writes:

> He knows the normal structure of the human body, the normal composition of the bodily fluids, the normal functioning of tissues and organs, the physiological action of ordinary drugs, the main departures from normal structure, and in a limited fashion the significance of such departures both to the organs and tissues . . . .[86]

Students begin by learning the parts of the body (anatomy), how they form (embryology & histology), and their function (physiology).[87] In the second year students should begin to understand drugs (pharmacology), causes and recognition of disease (bacteriology and pathology), and patient diagnosis.[88] This course progression pares back what was previously assumed to be the realm of the physician. Whereas 'baths, electricity, massage, psychic suggestion, dietics, etc.' were once a part of *materia medica*, a subset of pharmacological instruction, they were removed to allow doctors to focus on drugs of 'proved power.'[89] With this recommendation, the division of power between doctors and other healers like midwives became stark.[90] Simply by changing the breadth of material medical students were responsible for, the practice of medicine was able to differentiate itself from other forms of healthcare and attain a more elevated status. What is now colloquially known as *alternative medicine* was no longer perceived as being integral to the serious science of medicine, effectively vaulting physician practices to an elite level of care only accessible through expensive

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[79] *See id.*
[80] *See id.* at 76–77.
[81] *Id.* at 85–86.
[82] *See id.* at 88.
[83] *See id.* ("Post mortems are practically nil. None are claimed at . . . Atlanta . . . .").
[84] *See id.* at 93–94 (discussing the importance of "a good clinic in internal medicine").
[85] *See* ROTHSTEIN, *supra* note 12, at 174–75.
[86] FLEXNER, *supra* note 1, at 91.
[87] *See id.* at 61.
[88] *See id.*
[89] *Id.* at 65.
[90] *See generally* JOHN S. HALLER, AMERICAN MEDICINE IN TRANSITION: 1840–1910, at 150–91 (1981).

medical education. Flexner contributes to the medicalization of health through the promotion of an increasingly technical education for practitioners.[91]

The methods of knowing for which Flexner advocats relied on practices that have visible results a physician can measure. By learning a *normal* structure for human physiology, medical students would be able to *see* if a patient presented with abnormal structures. By focusing on drugs of proven power, Flexner shifts medicine toward a visible and tangible evidence of health. He writes, "It needs perhaps still to be emphasised that description is not substitute for tactile and visual experience, and that such experience, if intellegently controlled, both records and organizes itself with suprisingly little formal revamping."[92] Where ideas of promoting wellness were a part of medical instruction before his report, Flexner encourages schools to focus training on visually identifying sickness and disease and its alleviation. Students are encouraged to cultivate their skills of observation.[93] In his 1925 comparative study of the revamped American schools with schools in Europe, Flexner writes, ". . . the student's powers of observation should be actively excercised in accumulating additional information of more and more sharply differentiated quality, and in forming habits which tend to make all subsequent experience both informational and constructive."[94]

These curricular changes remain even as the breadth of what a medical student is expected to know has increased exponentially. Medical schools still adhere to a four-year curriculum, with the first two years largely lecture-based general education classes and the last two more clinical.[95] The survival of the four-year system speaks to its durability, but questions of efficacy remain as health outcomes in the United States still differ drastically from other industrialized peer nations. Flexner reconfigures medical education to center science one can see. In his copious notes on the schools he visited, he often chastises schools where students did not have access to patients and other forms of clinical learning.[96] Student access to microscopes, cadavers, skeletons, diagrams, and other types of didactic medical media demonstrates the importance of doctors-in-training visually assessing health, another facet of medical education that remains today. Questions of patient rapport and general bedside manner are entertained by Flexner but are not discussed in nearly as much detail as the scientific elements of medical education.[97] The doctor-patient relationship remains a site for medical education reform and study today.

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[91] ABBY L. WILKERSON, DIAGNOSIS : DIFFERENCE : THE MORAL AUTHORITY OF MEDICINE 18 (1998) ("Abraham Flexner understood Medicine as based strictly in physics, chemistry, biology, and related subdisciplines.").

[92] FLEXNER, *supra* note 1, at 62.

[93] *See generally* KENNETH M. LUDMERER, LEARNING TO HEAL: THE DEVELOPMENT OF AMERICAN MEDICAL EDUCATION 175 (1988) ("[Flexner] admired the 'scientific' practitioner–the one who evaluated patients carefully, who performed tests only when they were dictated by a patient's particular circumstances, who modified his preliminary impressions on the basis of test results or the response to therapy . . . .").

[94] ABRAHAM FLEXNER, MEDICAL EDUCATION: A COMPARATIVE STUDY 177 (1925).

[95] *See* DeWitt C. Baldwin, Jr., *The Medical Curriculum: Developments and Directions*, *in* BEYOND FLEXNER: MEDICAL EDUCATION IN THE TWENTIETH CENTURY, *supra* note 26, at 146–47.

[96] *See* FLEXNER, *supra* note 1, at 302–03.

[97] *See id.* at 91–92.

II. ALL THE WOMEN ARE WHITE AND ALL THE BLACKS ARE MEN[98]: FLEXNER ON RACE AND GENDER

Chapters thirteen and fourteen of the Flexner Report explicitly address the possibilities for women and "negro" medical students.[99] The discussion of these two groups in two distinct chapters models their position within medicine, on the fringe. Flexner's relative indifference toward women medical students and benevolent patriarchal reflection on Blacks in medical school reinforce that the ideal student is a white man.[100] Additionally, women are understood to be white and Negroes are understood to be men. Black women are discussed only briefly in the capacity of nurses in the Negro chapter and are not legible at all in the chapter on women, despite the fact that there were Black women physicians at the time and even in the South.[101] Black women are limited to a sentence of the Negro chapter as help mates to negro doctors in "educating the race to know and to practice fundamental hygienic principles . . . ."[102] Neither doctors nor patients, the role of Black women within medicine is portrayed as inconsequential.

Flexner's referential regard for Black women is not surprising given their devalued place in society let alone in the privileged space of medical education. However, the history of J. Marion Sims, Emory School of Medicine, and medical educational practices portends the opposite. J. Marion Sims, credited as the father of modern gynecology, achieved his posthumous celebrity through experimentations on Black enslaved women that led him to perform the first successful surgery to treat vesicovaginal fistulas.[103] A tear of the lining between the bladder and vagina, usually the result of difficult childbirth in malnourished women, creates a passage for the leaking of urine into the vaginal cavity.[104] Women with the condition were in a nearly constant state of discomfort, and, in the case of slave women, unable to work. Sims developed the procedure for treating fistulas by performing more than thirty surgeries (each) on the enslaved Black women Anarcha, Lucy, and Betsy, from 1845-1849.[105] They were regarded as ideal patients because Sims and others of the time believed that Black people had a higher tolerance for pain than whites. Sims remarked that his attempts to perform these surgeries on white women were unsuccessful because they could not stand the pain. This specious argument misses the differential power relation between a free white woman and an enslaved Black woman receiving *treatment*. Anarcha, Lucy, and Betsy could not say no to being the subjects of Sims' experiments, nor could they ensure that if they had said no, it would have been respected. Historian Diane Axelsen points out that enslaved women were conditioned to endure pain with a tight-lipped stoicism that was then equated with animal forbearance.[106] For this reason, Sims did not provide anesthesia for his patients even when it became available.[107] Despite the ethical questions surrounding Sims's work, he is still regarded very

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[98] This section title draws on the book title BUT SOME OF US ARE BRAVE: ALL THE WOMEN ARE WHITE, ALL THE BLACKS ARE MEN: BLACK WOMEN'S STUDIES (Gloria T. Hull et al. eds., 2d ed. 2015).

[99] FLEXNER, *supra* note 1, at 178–81.

[100] *See* FLEXNER, *supra* note 1, at 178–81.

[101] *See* FLEXNER, *supra* note 1, at 178–79; *see also* DARLENE CLARK HINE, BLACK WOMEN IN WHITE: RACIAL CONFLICT AND COOPERATION IN THE NURSING PROFESSION, 1890–1950 70 (1989).

[102] FLEXNER, *supra* note 1, at 180.

[103] Diana E. Axelsen, *Women as Victims of Medical Experimentation: J. Marion Sims' Surgery on Slave Women, 1845-1850*, 2 SAGE 10, 10–11 (1985).

[104] *Id.* at 10.

[105] *Id.* at 10–13.

[106] *Id.* at 11.

[107] *Id.*

positively, with numerous statues erected and awards granted in his honor.[108] Black women's bodies are central to the development of medical practices and are the most expendable human bodies on which medical students honed their skills.

Chapter thirteen of the Flexner Report specifically addresses the medical education of women.[109] Flexner believes that medical schools, at the moment of his report, were particularly receptive to women students.[110] In his estimation, women could attend any medical school (assuming they could travel alone to those various locations) as there was no law or statute barring them from doing so. Flexner reports that despite fewer medical schools, women's declining pursuit and matriculation at institutions represents a declining interest in the medical profession.[111] He suggests that because the majority of women who were in medical school went to coeducational insitutions, it was not fiscally responsible to develop women's schools at the expense of sharing those resources with men.[112] He proposes closing all of the women's colleges.[113] The chapter, which consists of a graph and three paragraphs, does not address the reality of the *otherness* of women in the world of medical education.[114] Prior to this chapter, women are not acknowledged in the report with the exception of one of the three women's medical colleges listed among schools that have poor standards and facilities for students.[115] Throughout his report, it is clear that Flexner imagines the prototypical student to be male. All of the pronouns used refer to a male-identified student body. Though using *he* universally was the proper language convention of the time, students are also referenced as *men* and *boys*.

Flexner's opinion can be best summed up with an indifference, which asserts that women have choice and agency to become doctors, but are largely uninterested. His dismissive position does not reflect the real social conditions that made it difficult for women to participate in medical school. Economic instability and social norms regarding the roles of women in society work together to hinder women's pursuits of medical degrees.[116] Flexner's inability to recognize these realities speaks to the ways in which his masculinist perspective colors his perception of marginalized identities and their relationship to the hegemonic world of medical education.

In chapter fourteen, Flexner deals explicitly with Black people, highlighting the particular North/South, Black/white, dichotomous understanding of race in the United States.[117] He begins rather ominously remarking, "the medical care of the negro race will never be wholly left to negro physicians."[118] The paternalism of this chapter

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[108] *See, e.g., Dr. J. Marion Sims*, CENTRAL PARK CONSERVANCY, http://www.centralparknyc.org/things-to-see-and-do/attractions/dr-j-marion-sims.html (2017) (describing J. Marion Sims statue erected in Central Park in New York City, New York); *Apply for a Grant,* J. MARION SIMS FOUND., http://jmsims.org/home/apply-for-a-grant/ [https://perma.cc/VMK4-34RE] (describing grants issued by the J. Marion Sims Foundation in Sims' honor).

[109] *See* FLEXNER, *supra* note 1, at 178–79.

[110] *See id.* at 178.

[111] *See id.*

[112] *See id.* at 179.

[113] *See id.*

[114] *See id.* at 178–79.

[115] *See id.*

[116] JANE LESERMAN, MEN AND WOMEN IN MEDICAL SCHOOL 12 (1981). Women were not admitted to the American Medical Association until 1915 and even then were not allowed to examine men's genitals, though gynecology and obstetric specialties were practiced by men. *Id.* For more on women in medicine, *see* MARY ROTH WALSH, DOCTORS WANTED, NO WOMEN NEED APPLY: SEXUAL BARRIERS IN THE MEDICAL PROFESSION 1835-1975 (1977); WOMEN IN MEDICAL EDUCATION: AN ANTHOLOGY OF EXPERIENCE (Delese Wear ed., 1996).

[117] *See* FLEXNER, *supra* note 1, at 180–81.

[118] *Id.* at 180.

seems to be in direct contrast to the ambivalence and even utilitarian nature of the proceeding chapter about women in medical education.

He reiterates what seems an obvious point for the time period, that negro physicians will work exclusively with negro patients; however, in doing so, he makes clear the report is for a white audience. He writes, "The negro must be educated not only for his sake, but for ours."[119] The necessity of repeating what seems self-evident exposes the anxiety around the concept of Black physicians treating white patients. He attempts to further allay fears around the projected deficiencies of the Black physician by pointing out that Black patients will undoubtedly be better served by their own doctors than by "poor white ones."[120] Flexner's point elucidates a reality that poor white physicians, possibly lacking funds and perhaps not preferred by white patients who have other options, are more likely to work with negro patients.[121] The importance of providing quality care for Black patients is alluded to here, though not named. The care of Black patients was negatively affected by a climate of racial tension between poor whites and Blacks, where white class insecurity was assuaged through ill treatment of Black patients by white doctors.

Flexner explains why negro health is of importance to whites, asserting that Blacks and whites live in proximity to each other and that, if Blacks contract diseases, they are communicable to nearby white population: "Self-interest seconds philanthropy."[122] Negro physicians and nurses should be most concerned with hygiene; other medical concerns are not discussed. Historian Todd Savitt writes, "Flexner not only limited the role of black physicians to caring for other blacks, but further restricted it to matters of public health."[123] Being able to care for Negros who are *taken in* is the kind of benevolent patriarchy that characterised the time. Flexner writes, "The negro needs good schools rather than many schools--schools to which the more promising of the race can be sent to receive a substantial education where hygiene rather than surgery, for example, is strongly accentuated."[124]

Of the seven medical schools for Blacks at the time, Flexner thinks only two are worth saving: Meharry Medical College in Nashville, Tennessee and Howard Medical School in Washington D.C.[125] The success of Meharry is credited to Dr. George W. Hubbard, a white physician who has "devoted himself singly to the elevation of the negro."[126] He praises the Negro graduates of Meharry for "remember[ing] their obligation to him and to their school."[127] His comments reflect a patriarchal understanding of his and other white men's role in relation to Black medical students. These two schools were the only places to educate Black medical students after the implementation of Flexner's recommendations.

The financial health of these two surviving schools was not insured. Howard University President Wilbur Thirkield embraced Flexner's report with open arms,

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[119] *Id.*

[120] *Id.*

[121] *See id.* Conversely, some Black doctors had trouble attracting Black clients because of internalized racism that made Black patients question the aptitude of Black practitioners. *See* JOHN DITTMER, BLACK GEORGIA IN THE PROGRESSIVE ERA, 1900–1920 35 (1980).

[122] *See* FLEXNER, *supra* note 1, at 180.

[123] Todd L. Savitt, *Abraham Flexner and the Black Medical Schools*, *in* BEYOND FLEXNER: MEDICAL EDUCATION IN THE TWENTIETH CENTURY, *supra* note 26, at 72–73.

[124] FLEXNER, *supra* note 1, at 180.

[125] *See id.* at 180–81.

[126] *Id.* at 181.

[127] *Id.*

adjusting entrance requirements and curriculum as noted.[128] When these measures notably reduced student enrollment and subsequently funds to sustain the school, Thirkield wrote to Andrew Carnegie and Flexner for help in procuring financial support.[129] Dr. Hubbard of Meharry made a similar request and was also rebuffed. Carnegie's reply was telling. "If we start helping medical colleges for coloured people we cannot discontinue."[130] The American Medical Association and the founders of the organizations that supported many medical schools agreed with Flexner's recommendations on the closing of most Black schools and on the limiting of funds for the two that survived.[131] The impact of this decision reverberates today.[132]

Flexner makes no mention of the potential for racially integrated medical education. In spite of his claims of need for more attention to negro health, he proposes the closing of five of seven schools that are available for negro doctors.[133] He argues for the concentration of resources for Black doctors at these two institutions. The realities for Black patients under Flexner's reimagined medical education system leave much to be desired as these patients are ignored in the estimates for the number of Southern doctors needed to serve the population. The realities for Black physicians and patients in the North are not addressed at all and leave lingering questions about how they fared in a reformulated medical education system that did not acknowledge their existence.[134]

Furthermore, negro doctors are assumed to be men. Black female physicians are not considered at all as he specifically genders the roles of doctor as men and nurse as women, which accounts for his only mention of Black women in the entire report.[135] Howard and Meharry had Black women students as early as the late 1800s.[136] Black women were not welcome at women's medical schools and, with his prediction of their imminent demise, it was not a line of inquiry that Flexner pursued.

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[128] Howard R. Epps, *The Howard University Medical Department in the Flexner Era: 1910-1929*, 91 J. NAT'L MED. ASS'N 885, 885-911 (1989).

[129] Todd L. Savitt, *Abraham Flexner and the Black Medical Schools*, *in* BEYOND FLEXNER: MEDICAL EDUCATION IN THE TWENTIETH CENTURY, *supra* note 26, at 75.

[130] *Id.* at 76.

[131] *See* JAMES SUMMERVILLE, EDUCATING BLACK DOCTORS: A HISTORY OF MEHARRY MEDICAL COLLEGE 54–55 (1983).

[132] *See* VERNON W. LIPPARD, A HALF-CENTURY OF AMERICAN MEDICAL EDUCATION, 1920–1970 104 (1974); KENNETH M. LUDMERER, TIME TO HEAL: AMERICAN MEDICAL EDUCATION FROM THE TURN OF THE CENTURY TO THE ERA OF MANAGED CARE 255 (1999); Molly Cooke et al., *American Medical Education 100 Years After the Flexner Report*, 355 NEW ENG. J. MED. 1339, 1343 (2006).

[133] SUMMERVILLE, *supra* note 131, at 54–55; *see generally* Todd L. Savitt, *Black Doctors: A Strong Medicine to Take in the New South,* CRISIS, Jan./Feb. 2001, at 26–30.

[134] It is important to note that the Flexner Report does not acknowledge Asian, Arab, Indigenous, Latino races or ethnicities. These identity categories were not intelligible at the time of Flexner's report. The realities for these non-white doctors cannot be gleaned from this document, although Asian and Latino students are visible in the Emory yearbooks. *See* JOHN D. MARTIN, JR. & GARLAND D. PERDUE, THE HISTORY OF SURGERY AT EMORY UNIVERSITY SCHOOL OF MEDICINE 237–46 (1979). The complete erasure of indigenous peoples in Flexner's report is an important omission because there was a great deal of representational imagery regarding their existence in the late 19th and early 20th century. *See, e.g.*, AMERICAN INDIANS AND POPULAR CULTURE (Elizabeth DeLaney Hoffman ed., 2012); DEVON A. MIHESUAH, AMERICAN INDIANS: STEREOTYPES & REALITIES (1996); S. E. WILMER, NATIVE AMERICAN PERFORMANCE AND REPRESENTATION (2009). The ways in which Indigenous bodies were used in medical experimentation and indigenous youth were adopted into white families does register them in the sight of a medical education review if only in the limited scope of *patients* in need. *See* ANDREA SMITH, CONQUEST: SEXUAL VIOLENCE AND AMERICAN INDIAN GENOCIDE 109–17 (2005).

[135] *See* FLEXNER, *supra* note 1, at 180.

[136] LAURAN A. KERR-HERALY, RACE, GENDER, AND AFRICAN AMERICAN WOMEN DOCTORS IN THE TWENTIETH CENTURY 7 (2010).

Flexner's report reinforces ideas about the education of white women and Black men that were already evident in the operations of medical institutions at the time. Though Flexner spares two Black medical schools, he offers no plan by which they can remain financially viable; a factor he considers with many other schools by encouraging consolidation. Black doctors were practicing in Atlanta during the early 1900s, although they were trained in institutions outside of Georgia.[137] There were only a few public hospitals where they could practice.[138] Legally, the education of Black doctors in the state was not possible. Although there were no specific laws segregating higher education or medical school, Georgia had passed several laws barring the integration of classrooms.[139] In 1906, the Georgia state assembly passed a law that punished schools that tried to integrate by removing all state dollars from the institution, effectively foreclosing any institution's willingness to try.[140] Court statutes and demographic shifts in Georgia, and specifically Atlanta, contributed to a climate of racial unrest characterized by violence.

Flexner's report is the guide that led to the consolidation of the medical schools in Georgia, but the implementation of the newly standardized medical education system fell to the administrators and faculty at the Atlanta College of Physicians and Surgeons turned Atlanta Medical College turned Emory School of Medicine.[141] The students are the ultimate barometers for how Flexner's proposals impacted the learning process. What kinds of site-specific medicine could have been possible if Flexner and colleagues paid attention to the unique contributions a Southern-grown medical practice could have provided? What might a Black physician cohort not attuned to hygiene have accomplished in this era? What would it have meant for Black women to be seen as potential doctors, themselves? Social values are being communicated to potential doctors. There is an image of the doctor that aligns with the idyllic preferences for physicians that Flexner outlines in his report. This representation of students that emerged from Flexner's report still impacts the demographics of medical schools to this day.

While there is no de jure discrimination in medical school ranks, the ways in which our social and legal systems limit opportunities for those most marginalized inadvertently contributes to a homogenous student body. Critical Race Theory of the health sciences is particularly useful in making the consequences of these realities visible. The language of intersectionality had yet to be coined by Kimberle Crenshaw at the time of Flexner's report, but her theoretical intervention still applies.[142] Race, gender, region, and class all intersect in the formation of the ideal doctor and patient that for Flexner has a very narrow window of possibilty. For the Carnegie Foundation, Flexner became a vehicle for creating equality in medical education. But this equality was premised on Flexner's own indifference towards women, derision of the South, patronizing of Blacks and outright dismissal of Black women.[143] This was not the expansive equailty that critital race theorists advocate for in the health sciences but a myopic and contigent equality that still revereberates in medical insitutions and practice now.

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[137] *See* Savitt, *supra* note 133, at 28.

[138] *See id.*

[139] *See* Vanessa Siddle Walker & Ulysses Byas, Hello Professor: A Black Principal and Professional Leadership in the Segregated South 20 (2009).

[140] *See* 1906 Ga. Laws 1105.

[141] *See* MARTIN & PERDUE, *supra* note 134, at 14–18.

[142] *See* Kimberlé Williams Crenshaw, *Race, Reform, and Retrenchment: Transformation and Legitimation in Antidiscrimination Law*, 101 HARV. L. REV. 1331 (1988).

[143] *See id.* at 1362.