American Medical and Intellectual Reaction to African Health Issues, 1850-1960: From Racialism to Cross-Cultural Medicine

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During recent decades, social scientists, particularly anthropologists, sociologists and medical historians, have looked increasingly at how social and cultural factors inform a society's medical community and vice-versa. As Roger Cooter recently stated, ". . . medicine is a social phenomenon capable of being properly studied only when treated as a part of its social, political, economic and cultural totality."[1] In America, a steady flow of medical sociologists—most notably Henry E. Sigerist in the 1940s, Talcott Parsons in the 1950s, David Mechanic in the 1960s and 1970s, and Vern and Bonnie Bullough in the 1980s—contributed numerous empirical studies that revealed that the development of American medicine was shaped moreso by its social and cultural context than clinical discoveries.[2] These studies have demonstrated conclusively that the American health profession's approaches to disease (etiology and therapy), the institutional structure of medical research and care, and public health care policy all have been deeply influenced by socio-economic and cultural factors specific to historical epochs of evolving American society.

At the same time that the socio-cultural context for medical care is gaining closer examination, social science researchers and health experts are placing greater importance on the ethnic and racial dimensions of health care. They stress that the spread of disease and illness within a society reflect not only economic barriers to medical services, but also ethnic and racial stratification. The mortality and morbidity rates of a society's minority populations, as well as the distribution of medical care and practitioners, mirror closely its ethnic and racial hierarchy. As Richard Cooper stated, "[i]n virtually every multi-racial society consistent patterns of differential mortality have been described."[3]

This study will present an historical overview of the connection between the social context and the collective perceptions of medical, anthropological, and social policy thinkers in the United States regard-

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ing health and illness of the black peoples of American and Africa. It will focus on the influence of race concepts in shaping health thought of the modern United States (Africa or Europe require separate studies). This investigation will outline the initial strength and subsequent decline of racial reductionism or "racialism" within these expert communities through the early twentieth century.[4]

The first stage in the modern racial conceptualization of health emerged in the nineteenth century. During this period this race-centric outlook dominant in the United States viewed black Americans and peoples of Africa as an amorphous biological group predisposed to the same diseases and ill-health, and generally inferior in physical and mental capacity compared to other "races."

After World War I a second stage in American health thought toward Africa unfolded. A serious split occurred when a new faction of anti-racialists emerged gradually among anthropologists and international philanthropists. These investigators uncovered empirical data that challenged phenotypical cataloging of "races" as well as demonstrated a complex mosaic of ethnicity and health ways and needs existed among African peoples. Through academic publications as well as the periodicals of social welfare organizations, this new medical and sociological insight into African communities challenged the health and policy-making communities of the United States.

The third phase in American health and race views developed following World War II. During this period a tremendous expansion in the flow of information regarding the variegated health conditions of African peoples occurred. This stream of empirical studies on African peoples' health gained momentum because of two other developments. First, specialized medical disciplines such as epidemiology and preventive medicine advanced throughout the medical communities of the United States and Europe. These medical fields stressed increasingly that specific unhealthy living conditions as well as lack of medical resources to manage infectious diseases were at the heart of health problems confronting typical African societies. Second, cultural relativism became a dominant theoretical focus in anthropology and social science generally. Last, there was a tremendous upsurge in United States political involvement in and direct aid to nations of Africa. In striving to gain greater political and military influence with post-colonial African countries, the United States for the first time initiated direct public-health assistance programs as part of this new foreign policy. These new medical, intellectual, and political movements of the 1940s and 1950s obliterated the static racialist thought toward the health situation of Africans common among medical and sociology circles prior to World War I.

The background to modern American thought on African health is rooted in the slavery period and the social doctrine of white supremacy that solidified during and immediately after the overthrow of Recon-

struction. During this period United States intellectuals and medical professionals had only sparse contact and direct knowledge of the ethnic and regional communities of African peoples. Studies of the African people of the slave South relating to a variety of subjects such as malaria and childbearing "established" that the physique of blacks was so obviously different from that of whites, treatment approaches had to be completely separate for the two groups.[5] The study by white antebellum southern physicians that epitomized the projection of racial categories (or pseudoscientific ideas) into medical classifications of disease was conducted in 1851 under the leadership of Samuel A. Cartwright and called the "Report on the Diseases and Physical Peculiarities of the Negro Race."[6] The Cartwright report exhorted that medical science and medical schools had been historically non-existent in Africa, hence the need for this "investigation" on "the diseases and physical peculiarities of our negro[sic]population . . . ."[7] The Cartwright study pointed out that "anatomical" and "physiological" traits were at the root of black-white disease differentials. Besides the color of the skin, the Cartwright report found racial differences "in the membranes, the muscles, and tendons and in all the fluids and secretions . . . . [e]ven the negro's brain and nerves . . . are tinctured with a shade of pervading darkness."[8]

The racial classification scheme of this medical group based on physical/biological traits and disease propensities allegedly unique to African populations (whether located in the Americas or the continent of Africa) was readily accepted by Charles Darwin, perhaps the most influential thinker of nineteenth century American and British scientists studying "races." One of the most important treatises on race that emerged in the late nineteenth century United States and Britain was Darwin's *The Descent of Man and Selection in Relation to Sex* (1871).[9] In this work Darwin cites as authoritative studies of black and mulatto slaves by antebellum American scientists. Focusing on human (as opposed to animal) evolution, he expounded at length about the anatomical distinctions between blacks and whites. Darwin believed that "it would be an endless task to specify the numerous points of difference" between black Africans and whites.[10] He held that these distinctions were fundamental or constitutional, stating:

> There is . . . no doubt that the various races, when carefully compared and measured, differ much from each other—as in the texture of the hair, the relative proportions of all parts of the body, the capacity of the lungs, the form and capacity of the skull, and even in the convolutions of the brain . . . . The races differ also in the constitution, in acclimisation [sic] and in the liability to certain diseases. Their mental characteristics are likewise very distinct; chiefly as it would appear in their emotional, but partly in their intellectual, faculties.[11]

The separate physical classification of whites and Africans intensified during the late nineteenth century when the stream of missionaries sent

to Africa by American church denominations grew significantly. With slavery now abolished, and American Indian communities subordinated, religious bodies throughout the nation saw the "Christianization of Africa" as a central moral cause.[12] A markedly high mortality rate occurred for black and especially white American and British missionaries to Africa. News of these missionaries' death rates coincided with the expanding popularity of social Darwinism, bolstering racial thought that Africa represented an area of physical degeneracy and ill-health. The high mortality rate of white missionaries—for example, it has been estimated that as high as fifty percent of white British missionaries to early nineteenth century Africa died[13]—reinforced the stereotype that Africa was the "White Man's Grave." The substantially lower black missionary mortality was rationalized as further proof that African people were physiologically distinct from members of the white race. Indeed, black missionaries were put in the African regions by white-controlled American denominations on the theory that these black evangelists fared a much better chance of surviving.[14]

During the early decades of the twentieth century the notion that Africans here and abroad possessed a peculiar physical commonality became, if anything, more influential. Indeed, the tremendous destruction incurred during the Great War did not lessen but, instead, strengthened the use of racial classification and the "national psyche" idea to explain political, colonial, and national conflicts. For example, even the liberal American social psychologist Herbert Adolphus Miller did not dispense of the racial stock approach. In his influential study *Races, Nations, and Classes: The Psychology of Domination and Freedom* (1924), he grouped humankind into "vertical" groups of races and nations, and "horizontal" groups such as the classes and sects within a particular nation.[15] In struggles between vertical groups—such as Czechs versus Austrians, the Poles versus the Germans, the Jews versus Gentiles, the Korean versus the Japanese, and the Negro versus the white—an "oppression psychosis" resulted. These competing groups popularized "a neurotic fiction of superiority" toward their competing vertical or horizontal group. But note that this theory did not aim to eliminate the rigid classification of Africans and whites into separate races—races that possessed fundamentally different biological, physical and intellectual characteristics.[16] Also, James H. Breasted, the prolific and influential American orientalist, emphasized fundamental distinctions between black Africans and whites, going so far as to "whiten" the ancient Egyptians.[17]

In addition to social scientific thought that was framed within a crude racial schematic in which black and white human communities were viewed as separate biological, physical, and psychic races, actual medical and anthropological information from locales in African nations was, at best, meager. In colonial Africa through the middle 1930s organized medical research projects and facilities were sparse. Instead,

there emerged a discombobulated web of European colonial and missionary medical personnel unevenly spread throughout the continent. For instance, British colonial medical centers throughout the East African territories (today's Kenya, Uganda, etc.) were seriously deficient. These medical stations prior to World War II lacked funds and personnel such as trained indigenous medical experts. These conditions reflected the low priority that British policymakers assigned to comprehensive health and information resources in these regions and precluded formalized medical research.[18] The neglectful British health policy was compounded by the structural weaknesses of African societies such as poor transportation and communications systems, as well undeveloped higher education, formal health institutions, and the other industrial and technological resources that were complementary requirements for medical research along the Western model.[19].

The exploits and sensational writings of European medical missionaries, especially Albert Schweitzer, also had a substantial impact on sustaining American academic and popular thought toward Africa as a continent filled with a distinctly needy and unhealthy people. His book *On The Edge of the Primeval Forest* gave extensive accounts of his work as a physician among "the natives of Equatorial Africa."[20] The romantic image of the "jungle doctor" was frequently seized upon by Americans who addressed African affairs both in the popular press and black social welfare tabloids. A 1925 issue of *Opportunity*, the publication of the National Urban League, contained a review of *On the Edge of the Primeval Forest* that quoted Dr. Schweitzer's comments regarding his encounters with hapless African patients:

> The operation is finished, and in the hardly lighted dormitory I watch for the sick man's awakening. Scarcely has he recovered consciousness when he stares about him and ejaculates, again and again: "I've no more pain! I've no more pain." His hand feels for mine and will not let it go. Then I begin to tell him and the others who are in the room that it is the Lord Jesus who has told the doctor and his [nurse]wife to come to the Ogowe, and that white people in Europe give them the money to live here and cure the sick Negroes.[21]

While most early twentieth century American biologists, anthropologists, and health philanthropists envisioned Africa as overriden with diseases and psychological fatalism—due to its peoples' racial traits or widespread social degeneracy—after World War I a dissenting view on African health also began to emerge. A small but substantial community of scholars disputed the blanket generalizations that black Africans tended to have greater illness than whites. One leading voice of this dissent was Franz Boas, a Columbia University professor of anthropology who since the early 1910s challenged the concept of phenotypically distinct races both in his academic research and public commentary.[22] During 1925, for instance, Boas co-authored an article in the popular periodical *American Mercury* with Ales Hrdlicka, a

Smithsonian Institute anthropologist, urging that there was no conclusive proof of people of African descent possessed an inherent "racial" weakness.[23]

Also during the mid-1920s, the American anthropologist and leading scholar of African cultures Melville J. Herskovitz pointed out that racialism was on the rise in both intellectual and political circles. In a paper he read before the Association for the Study of Negro Life and History (ASNLH) in Philadelphia on April 3, 1924, Herskovitz stated that "[t]he subject of race itself has taken on a significance that is much greater than it was a short time past, as we find claims and counter-claims, not only as to the physical, but even the psychical characteristics of 'races.'"[24] In this study, Herskovitz examined skin tone, head-form, and other physical features of 1,000 black boys of a Manhattan public school. He suggested that if criteria for pure race (physical) traits could be established and applied methodically, racial crossing would perhaps be verified. That Herskovitz aimed to develop anthrometric criteria which could, in turn, verify that pure races no longer existed was considered a strident attack against the rising popularity and intellectual proponents of racial classification of all blacks as racially distinct during these times. Hence, it is not surprising that both the ASNLH and the Urban League provided a forum for Herskovitz's early findings.

At the 1925 meeting of the American Association for the Advancement of Science, George Draper of Columbia University responded against the growing opinion that race was not a strong determinant of health. Draper represented the majority "new" racialist arguments. He conceded that it was impossible to delineate specific boundaries between black and white races solely on the basis of external appearance. But he set forth the idea that racial groupings could be based on disease susceptibility or, that is, hereditary genotypical traits instead of "color."[25]

The dissenting minority school within the still newly developing fields of anthropology, anthrometry, modern human biology, and sociology was represented by scholars like Boas, Hrdlicka, Herskovitz, W. Montague Cobb, and W.E.B. Du Bois. But most other skeptical black and white social scientists of the interwar period lacked a substantial body of technical academic literature that could be the intellectual basis for challenging the "scientific" explanation of racial distinctions between whites and black Africans. These liberal intellectuals felt compelled to take a middle ground on the race-health controversy. While cautious about refuting the idea that Africans and black Americans were racially prone to greater illness than whites, these philanthropists focused on immediate inhumane social processes (such as caste systems and poverty) as strong influences on racial distinctions in intelligence tests and health status. In turn, these social reformists championed educational and other humanitarian reform measures for African communities to lessen the impact of these negative sociological or "environmental" factors.

One of the most influential theorists of this "accommodative" racial policy was Thomas Jesse Jones, the educational director of the Phelps-Stokes Fund. Around 1922 the Fund, along with leading missionary organizations of Canada, Great Britain, and the United States, issued a report, "Education and Africa," which called for extensive exportation of the Hampton-Tuskegee model to central and west Africa.[26] In 1924 Jones, in connection with the International Education Board (a subsidary of the General Education Board of the Rockefeller Foundation), published another report, "Education in East Africa." It too aimed at uplifting black Africans, not examining the politics of racial thought or "scientific" arguments for racial distinctions. As one reviewer of "Education in East Africa" wrote, Jones's survey centered on the educational facilities "for the two great groups of Negro stock"—namely Afro-Americans and black Africans.[27] Jones' chief ideas about African education did not stress "formal pedagogy," but the total welfare of the black African such as "personal hygiene and communal sanitation, infant mortality and malnutrition, the production, preservation and preparation of food, and related subjects."[28]

In 1926, James A. Tobey, a distinguished American biologist and public health planner also emphasized that a wretched environment for members of the black race here in America, and not racial determinism, should be stressed in attacking the problems of health that faced black Americans. Tobey did not discount the idea that racial factors had the dominant influence on black health, but insisted that "[i]n the case of the negro [sic] . . . the evidence seems fairly conclusive that environment is at present a tremendous factor in his well-being."[29] He also stressed that a question which should be pursued related to the effect that "admixture of white and negro blood has upon the health and longevity of the [black] race."[30] Thus, Tobey's ideas, along with those of other popular scholars like the sociologist Edward B. Reuter, did not signal an elimination of scientific racism, but only a reformulation of it.

The split in the racial interpretation of black American and black African health intensified during the 1930s. With the United States still fundamentally not involved in political and economic affairs of nations on the African continent, knowledge of the health status and epidemiology of African peoples remained largely blocked by race-centric idea now focusing on more subtle genotypical factors. Samuel J. Holmes, the influential biologist and eugenisist of the 1920s and 1930s, epitomized this reaffirmation of conceptualizing black health problems through the racial lens.[31] Writing in 1937, Holmes admitted that the "subject of differential mortality is full of pitfalls," yet still maintained that "different diseases affect the two races in different ways."[32] Unlike previous biologists and medical thinkers who deduced sweeping generalizations about the cause of black mortality from death rates calculated for a few diseases, Holmes proceeded to review the medical studies of racial incidence and mortality in dozens of specific disease catagories. He

concluded that blacks were more susceptible to certain diseases like tuberculosis and pneumonia, whites moreso to measles and diseases of the skin.

To Holmes, the basis for the discrepancy in mortality rates between blacks and whites was partially environmental but also genetic. He stated that "the important role of genetic factors in disease resistance, which has been demonstrated in different races of plants and animals, makes it very likely a priori [sic] that races so different as the Negro and the Caucasian may differ in their reactions to pathogenic agencies."[33] As Holmes surveyed disease mortality among black and white Americans, he developed the conclusion that the subject of the evolution of the races should not be discharged as a central biological issue merely because medical studies point to a need for specificity in describing interracial health distinctions. To the contrary, Holmes viewed that with the increase in black American population "competition for the means of subsistence is bound to go on [between blacks and whites]. Even though they may interbreed and eventually fuse into a single hybrid stock, the two groups will, in the meantime, inevitably engage in a struggle for numerical supremacy."[34] The apparent meticulous quality of Holmes' investigation, its meld between orthodox evolutionism and new epidemiological data, won the study the full endorsement of Robert E. Park, a leading figure among pre-World War II American sociologists of race relations.[35] But others, like the prominent anatomist and medical anthropologist W. Montague Cobb, criticized Holmes for failing to address the full implications of his own (i.e. Holmes's) biological race-war scenerio. Cobb wondered, for instance, why Holmes did not discuss the potential that all Americans could become some sort of "black" racial nation given the healthy population growth black Americans were experiencing.[36]

In the late 1940s and 1950s the medical thought on disease susceptibility of black Africans shifted substantially away from evolutionism and anatomy as the basis for explaining differing disease susceptibility between blacks and whites. Instead, American-based medical and biological thinkers focused on the impact of urbanization, industrialization and the availability of health services to explain mortality differentials between black and whites. This new socio-medical perspective explained that epidemics of tuberculosis in Africa, for instance, resulted from numerous immediate environmental factors such as the unsanitary living conditions, absence of public education regarding health matters and lack of prior exposure among many African populations to tuberculosis which tends to trigger natural immunity within later generations.[37] The new socio-medical view also posited a strong association between the incidence of tuberculosis and industrialization.

Rene Dubos, one of the nation's and world's leading biologists and anthropologists, emphasized in 1952 that black African populations suffered tuberculosis rarely until placed in contact with a carrier people—

such as in 1803 and 1810, when the British Government imported 4,000 blacks from Mozambique into Ceylon to form new regiments. Over 90 percent of these Mozambiquans died from tuberculosis by December of 1820. Another example highlighted by Dubos concerned World War I when tuberculosis also spread rampantly among France's Sengalese troops and the so-called "Capetown boys" when these soldiers entered France.[38]

But the most convincing evidence Dubos cited that pointed to material conditions and not racial traits of African people as the foundation for the seemingly high susceptibility of black Africans to tuberculosis were the studies of this disease's impact on Bantu populations of South Africa. Those Bantu people working in urban Johannesburg and other urban centers exhibited some of the highest mortality rates from tuberculosis in the modern world. But contrary to the prediction based on race traits, when these urban Bantu returned to their largely agrarian homesites where they retained their ancestral way of life based on family associations, tuberculosis mortality did not rise significantly. Thus, Dubos stressed that the disease was most prevalent among the reputedly "pure" Africans because of conditions of urban poverty.[39]

During the late 1940s and 1950s other developments fed the increasing knowledge of the limits of biological and genetic definitions of races, and refinements in specialized medical fields such as preventive medicine, and medical sociology changed radically the study of African health subjects. Also, as anthropology came of age as a discipline, the notion of cultural relativism spread in the post-World War II United States and the West.[40]

This author surveyed the number and specialties of medical articles on illnesses and medical care issues affecting American blacks and peoples of African societies that appeared in American and other English-language medical journals from 1925 to 1945.[41] During 1925 fifteen articles dealing with blacks were published in the nation's medical journals, but only two of these articles pertained to African blacks. By 1940 the number of articles on blacks generally had climbed to 44 and more than one-quarter (13) of them covered black African medical matters. The flow of studies on blacks generally and African peoples in particular increased still further over the next five years. In 1945 there were 24 articles published on African medical cases and 36 others relating to American blacks. These 1945 studies spanned some fifteen different medical specialities including pediatrics, hematology, infectious diseases, cardiology, and public health medicine.

This trend away from the idea that African health was predetermined by the racial make-up of the African population did not stem solely from intellectual growth and exchange within American academic medicine. The defeat of reductionist racial views of African health also derived from the expansion of the United Nations as a major force in international social science and public health campaigns. In 1950, 1951, and

1956 Unesco issued statements authored by many of the world's leading biologists and social scientists against racism and racial discrimination and denouncing the alleged scientific validity of racial categories. These scholars' studies appeared in an historic publication, *The Race Question in Modern Science* (1956) which aimed to undercut racialism "at the level of information and ideas, but [also] in the broader context of United Nations action to combat racism."[42]

Finally, political and military contacts by the United States with African nations greatly accelerated at the end of World War II. In order to solidify this new foreign policy linkage, the United States developed and implemented numerous public health assistance programs to specific African nations. The uneven, lackadaisical approach to African affairs that characterized much of United States foreign policy prior to the 1940s came to an abrupt halt as the period of African Independence sped forward. The political quandary that the United States found itself in regarding African affairs during the 1950s and early 1960s was described by one of the leading scholars of American-African policy, Rupert Emerson. Writing in 1967, Emerson stated: "The independence of almost all African colonies has brought with it an immense increase and diversification of American relations with Africa, but the task of accomplishing even a minimum of what remains to be done has barely been started. The potential centers of trouble are legion, [especially] in the vast southern end of the continent which clings to white domination."[43] By 1960 the United States had to wrestle with quickly developing concrete assistance programs for each of these forty or so new African nations. Medical aid and technical assistance began to flow from the United States to African countries because such charity would expand America's leverage over other super powers vying for the political, military, and economic benefits that the independent African nations offered.[44]

In summary, American medical and social thought regarding black Americans and Africans underwent a fundamental shift from 1850 to 1960. The shift was from an approach to African health that posited blacks in both the United States and Africa had common phenotypical "racial traits," to one that particularized the medical status and needs of African people according to their specific ethnicity, living conditions, and preventive medicine resources. This study suggests that ethnic chauvinism blunted understanding of health and medical conditions of a non-white racial groups both domestically and abroad. Such chauvinism eroded only under the pressure of countervailing scientific, crosscultural, and interdisciplinary knowledge.

Indeed, this pre-1960 transformation from racial reductionism to cultural relativism and scientific humanism was just the formative period of what is now a vibrant field of education and research centered on cross-cultural health concepts and ethnomedicine. Anthropologists, social historians and medical and nursing practitioners specializing in

preventive medicine have shown increasingly that while diseases are most effectively defined in biomedical terms, typical social populations interpret illness culturally.[45] Moreover, as medical anthropologist Michael Laguerre points out, culture provides "on the one hand, a grammar to interpret and understand an array of physiological and psychological symptoms and, on the other hand, both healers and remedies to cure real or perceived illnesses."[46] In the future, then, as both environmental and microbiological threats to humankind push their way to the top of the nation's public agenda, ethnic studies educators and researchers should intensify their focus on comparing cross-national medical thought and systems, as well as divergent cultural reactions to disease.

Notes

[1]R. Cooter. "Anticontagionism and History's Medical Record." *The Problem of Medical Knowledge: Examining The Social Construction of Medicine*. Peter Wright and Andrew Treacher, eds. (Edinburgh: Edinburgh University Press, 1982), 87.

[2]Representative writings of these scholars include: *Henry E. Sigerist On The Sociology of Medicine*. Milton I. Roemer and James M. MacIntosh, eds. (New York: MD Publications, 1960); T. Parsons and Renee C. Fox. "Illness, Therapy, and the Modern Urban American Family." *Journal of Social Issues*. Vol. 8 (1952) 31-44; D. Mechanic. "Social Psychologic Factors in Presentation of Bodily Complaints." *New England Journal of Medicine*. Vol. 286 (1972) 1132-1139; V.L. and B. Bullough. *Health Care For The Other Americans*. (New York: Appleton-Century-Crofts, 1982).

[3]Richard Cooper. "Race, Disease and Health." *Health, Race & Ethnicity*. Thomas Rathwell and David Phillps, eds. (London: Croom Helm, 1986) 21.

[4]By "racialism" this author is referring to a belief in the concept of race as scientifically valid. This concept emerged with the turn of the century and was widely accepted in modern American biological and social sciences prior to the 1950s. Its definition was enunciated succinctly by a leading American anthropologist, Earnest A. Hooten (1887-1954): "A race is a great division of mankind, the members of which, though individually varying, are characterized as a group by a certain combination of morphological and metrical features, principally non-adaptive, which have been derived from their common descent." Cited by Louis L. Snyder, *The Idea of Racialism*. (Princeton, NJ: Van Nostrand, 1962) 10.

[5]James H. Jones. *Bad Blood: The Tuskegee Syphilis Experiment*. (New York: Free Press, 1981) 18-19; Winthrop D. Jordan. *White Over Black: American Attitudes Towrd the Negro, 1550-1812*. (Baltimore: Penguin, 1968) 257-265, 532 ff.

[6]S. A. Cartwright. "Report on the Diseases." The New Orleans Medical and Surgical Journals. Vol. 7 (May 1851). Reprinted in *Concepts of*

Health and Disease: Interdisciplinary Perspectives. Arthur L. Caplan, *et al,* eds. (Reading, MA: Addison-Wesley, 1981) 305-325.

[7]**Ibid.**, 305.

[8]**Ibid.**

[9]Excerpts of *The Descent* appear in Marston Bates and Philip S. Humphrey, eds. *The Darwin Reader.* (New York: Scribner's, 1956) 263 ff.

[10]**Ibid.** 288.

[11]**Ibid.**

[12]Walter L. Williams. *Black Americans and the Evangelization of Africa: 1877-1900.* (Madison, WI: University of Wisconsin Press, 1982) 5.

[13]Dennis G. Carlson. *African Fever: A Study of British Science, Technology, and Politics in West Africa, 1787-1864.* (Canton, MA: Science History Publications, 1984) xvi, 10; K. David Patterson. "The Disease Factor: An Introductory Overview." *Disease in African History: An Introductory Survey and Case Studies.* G.W. Hartwig and K.D. Patterson, eds. (Durham, NC: Duke University Press, 1978) 3-24.

[14]Williams, 6-10. No systematic study of black American missionary mortality has been done. However, disparate evidence so far suggests that their death rates also were, like whites, extremely high; a refutation of the original presumption that blacks sent to Africa sustained better health. See, David McBride. "Africa's Elevation and Changing Racial Thought at Lincoln University, 1854-1886." *Journal of Negro History.* Vol. 62, No. 4 (October, 1977) 363-377.

[15]H. A. Miller. *Races, Nations, and Classes.* (Philadelphia: J. B. Lippincott Co., 1924).

[16]On Miller's conservative view of race assimilation, see R. F. Wacker. *Ethnicity, Pluralism, and Race: Race Relations Theory in America Before Myrdal.* (Westport, CT: Greenwood Press, 1983) 24-26, 29, 50-51.

[17]James H. Breasted. *The Conquest of Civilization.* (New York: Harper & Bros., 1926). In later decades, leading black African scholars excoriated Breasted for his distortion of Egyptian racial features. See Chikh Anta Diop. *The African Origin of Civilization: Myth or Reality.* (Westport, CT: Lawrence Hill, 1974) 132-33.

[18]Ann Beck. *A History of the British Medical Administration of East Africa, 1900-1950.* (Cambridge, MA: Harvard University Press, 1970) 194-197.

[19]**Ibid.**; National Academy of Sciences—National Research Council, Division of Medical Sciences. *Tropical Health: A Report on a Study of Needs and Resources.* (Washington, DC: 1962), Albert B. Sabin, "Preface," viii.

[20]Elizabeth Walton, rev. of *On The Edge of the Primeval Forest,* by Albert Schweitzer, *Opportunity.* Vol. 3, No. 34 (October, 1925) 315.

[21]**Ibid.**

[22]Wacker, 15-19.

[23]"Social Progress." *Opportunity.* Vol. 3, No. 25 (January, 1925) 63.

[24]M. Herskovitz. "Preliminary Observations in a Study of Negro-White Crossing." *Opportunity.* Vol. 3, No. 27 (March, 1925) 69.

[25]"Social Progress."

[26]William H. Baldwin. "A School System For Africa." *Opportunity.* Vol. 3, No. 31 (July, 1925) 201-204.

[27]**Ibid.**, 201.

[28]**Ibid.**

[29]J. A. Tobey. "The Death Rate Among American Negroes." *Current History.* Vol. 25, No. 2 (November, 1926) 220.

[30]**Ibid.**

[31]Samuel J. Holmes, *The Negro's Struggle For Survival.* (Berkeley, CA: University of California Press, 1937).

[32]**Ibid.**, 47.

[33]**Ibid.**, 48.

[34]**Ibid.**, 1.

[35]On Robert Park's support of Holmes' ideas, see R. E. Park. "The Nature of Race Relations." [1939] *Race and Culture: Essays in the Sociology of Contemporary Man.* (New York: Free Press, 1950) 105-106.

[36]W. M. Cobb. "Negro Survival." *Journal of Negro Education.* Vol. 7, No. 4 (October, 1938) 564-565.

[37]World Health Organization. *The Medical Research Programme of the World Health Organization, 1964-1969—Report by the Director General.* (Geneva: World Health Organization, 1969) 60-61; National Research Council. *Tropical Health.* 36-38. Also see Harry F. Dowling. *Fighting Infection: Conquests of the Twentieth Century.* (Cambridge, MA: Harvard University Press, 1977) 80-81; R. Cooper. "Race, Disease and Health." 58-59.

[38]Rene Dubos and Jean Dubos. *The White Plague: Tuberculosis, Man and Society.* (Boston: Little, Brown, 1952) 192.

[39]**Ibid.**, 194.

[40]Frances Herskovitz (ed.). *Cultural Relativism.* (New York: Random House, 1972); Susan S. Hunter. "Historical Perspectives on the Development of Health Systems Modeling in Medical Anthropology." *Social Science and Medicine.* Vol. 21, No. 12 (1985) 1297-1307.

[41]This author surveyed the bibliographic entries related to Negroes or Blacks in the National Library of Medicine (Bethesda, Md.) publication, *Cumulated Index Medicus,* volumes for *1925, 1940,* and *1945.*

[42]Unesco, ed. *The Race Question in Modern Science* (1956), Rpt. Leo Kuper, ed. *Race, Science, and Society.* (Paris/New York: Unesco and Columbia University Press, 1975) 3.

[43]Rupert Emerson. *Africa and United States Policy.* (englewood Cliffs,

N.J.: Prentice-Hall, 1967) 7.

[44]A key document that illustrates the new emphasis on health aid in U.S. and African foreign policy ties is Willard L. Thorp [Assistant Secretary of Economic Affairs]. "A Common Responsibility for Achieving Health Security." *The Department of State Bulletin.* Vol. 26, No. 667 (April 7, 1952) 541-544.

[45]Ann McElroy and P. K . Townsend. *Medical Anthropology in Ecological Perspective.* (Boulder, CO: Westview, 1985) 49.

[46]Michel S. Laguerre. *Afro-Caribbean Folk Medicine.* (South Hadley, MA: Bergin & Garvey, 1987) 86.

Critique

Theories about inherent racial characteristics, both those purporting to be scientifically (empirically) based and those emanating from the "soft" sciences, have changed dramatically over the past century and a half. As David McBride notes, the basis for research about the etiology of disease and the provision of health care in the United States has been and continues to be empirically questionable. McBride further argues that the American health care approach has been significantly influenced by cultural, social, and economic factors which had little or no relation to scientific truth.

This article progresses in a clear and easily understood fashion through three distinct and identifiable historical periods. McBride notes that the mid-nineteenth century was typified by the view that blacks were a specific racial group predisposed to certain illnesses and general poor health. In *The Red and the Black*, Hoover supports the view that American blacks were believed to be inferior because they were descendants of Africans, who, it was claimed, lacked civilization.[1] Black inferiority was substantiated in various ways. The Bible was frequently cited as the historical source for proof of the black race's baseness; the prevailing notion here was that blacks had been created prior to Adam, and therefore, were not of human origin, but rather were cousins, albeit higher functioning, of apes.[2] This notion, if believed, formed the basis for contending that blacks lacked a soul and was virulently racist. As McBride notes, the other commonly cited argument used to prove black inferiority was based on the works of Charles Darwin. Charles Brace, a reformer, employed Darwin's research which held that man had originated in one place, but had then migrated to various climatic areas which caused the evolution, through natural selection, of permanent, differing racial types. That these racial types were not equal was confirmed by Brace's argument that intermarriage between different