

The Flexner Report and the African-American Health Experience: Black Collective Memory and Identity as Shaped by Afro-cultural Trauma and Re-membering

Jasmine Arrington

College of Arts and Science, Vanderbilt University

The 1910 Flexner Report was a seemingly benevolent document intended to standardize medical education and increase the quality of physicians in the United States. Despite good intentions, it was a document with implications for African-Americans. The Flexner Report caused the closing of historically black medical schools, leaving two in the nation – Howard Medical School in the North and Meharry Medical College in the South. African-Americans were excluded from the institution of medicine, leaving blacks vulnerable to institutional abuses in health that facilitated distrust and disenfranchisement. This paper argues that despite the trauma experienced from violation and exclusion, Meharry Medical College serves as a chronotope that helps rebuild and symbolically re-member black collective identity and memory within and beyond medical education. The trauma includes present day black medical students and physicians not considered the equals of their white counterparts and black patients who suffered physical abuse and the infringement of self-determination. That created crises in collective African-American identity, sparking social pain. The Flexner Report is deeply implicated in structural inequality that has systematically disenfranchised African-Americans in medical education. Moving beyond structural inequalities, the Flexner Report is an unacknowledged source of trauma in the collective African-American health experience with both literal and figurative ramifications.

The Flexner Report was a seemingly benevolent document with traumatic racial implications for African-Americans and their health experience. In the United States in the early 1900s, actions were taken to organize and enhance the field of medical education to address health care concerns. The Flexner Report changed the institution of medicine in the United States through the closing and standardization of medical schools. Exclusion and violation experienced by black medical students, physicians, and patients historically and in the present day are markers of trauma that not only made African-Americans vulnerable to institutional abuses but fostered distrust and marginalization. Meharry Medical College is a site of healing for African-American collective identity. With its history of educating African-American physicians and addressing black health disparities through service to the Nashville and rural communities, Meharry serves as a chronotope that has helped rebuild and symbolically re-member black collective memory.

To evaluate the complex relationship between the Flexner Report and the African-American health experience in proper context, this paper establishes the history of black healthcare and medical education first. Then the events that primed the commissioning of the Flexner Report are discussed along with the document

itself. This paper then applies the novel theory of afro-cultural trauma to the Flexner Report, which I argue is reflected in African-American collective memory and identity. Afterward, post-Flexner crises in the African-American community – forced sterilization and the Tuskegee syphilis experiment – are also explored with respect to collective identity. Lastly, the reconstruction and re-membering of the legacy of black medical education is analyzed through Meharry Medical College as a chronotope that both literally and figuratively heals the African-American community and re-claims Black medical education. This approach is novel because the Flexner Report has only been evaluated for its structural effects. Going a step further, theory is used to ascribe meaning to the Flexner Report as source of trauma and Meharry is evaluated as a site of intervention.

The African-American community, more accurately referred to as communities, is diverse and full of varied health experiences. At the same time, institutional and systemic powers have subjected raced black bodies to a general disenfranchised, marginalized and traumatic health care experience that dates back to slavery. To operationalize the black health experience, this paper focuses on the collectivity, not individual experiences. That shared experience not only unifies

blacks, thus giving a sense of collective identity, but it also establishes a collective memory of shared experience that is constantly fragmented, rewritten and reclaimed by subsequent generations.

HISTORY OF AFRICAN-AMERICAN HEALTHCARE AND MEDICAL EDUCATION

During the colonial period in the early 1700s, African slaves were test subjects for surgeries and experimental procedures. Since slaves were property, no consent was needed from them. Instead, slave owners gave consent and were fully compensated by the physicians conducting experiments. Compensation typically included free, “food, lodging, clothing, medicine – everything associated with the procedure.”¹ Cultural and social attitudes of a slave society facilitated the abuse and desecration of black bodies. From a colonial perspective, African bodies were perfect for physicians to experiment on because they were not valued, in abundance, replaceable, and only quasi-human.² Ever since Africans were enslaved and brought to what we know to be the United States, race was a dehumanizing social construct synonymous with loss of self-determination. That loss of autonomy was also a reality for slaves and their health because their owners and physicians determined what medicine they would be given and how their bodies would be treated. Founded on scientific racism, “research” and “theory” at the time justified the treatment of slaves. In reality, biased studies were conducted and conclusions drawn from observation to justify slavery. The use of science, and consequently medical institutions, to maintain social hierarchy makes scientific racism inherently political.³ Therefore, medicine and science are inherent mechanisms of racism.

During the Civil War and post-slavery in the age of reconstruction, African-American health was disregarded until disease began to impact whites. Although the causes of diseases like TB and malaria were unknown at the time, it was recognized that maintaining certain living conditions minimized disease. During the Civil War many blacks ran away to the North to be under Union protection. Declared contraband, African-Americans were confined to overpopulated areas of land. Living in close quarters without proper sanitation or clean water sparked

disease.⁴ To address that, the sanitation commission had people build “sewers, to remove dead animal bodies from the populated areas, and to whitewash streets with lime.”⁵ These efforts were not taken because there was a concern for African-American health, but rather to protect white Union soldiers from falling ill.

African-Americans sought to formally enter the medical profession around the early to mid-1800s. With medical institutions being beacons of power in the United States, blacks were barred from medical schools. In 1837 James McCune Smith, an abolitionist and suffragist, became the first African-American to attain his medical degree but he had to do so abroad in Scotland at Glasgow University because no American college would admit him.⁶ David Jones Peck was the first black doctor to earn a medical degree in the United States in 1847. The son of prominent abolitionist John Peck, David Peck attended Rush Medical College in Chicago.⁷ Those pioneering blacks in the field of medicine were either politically active themselves, or came from households of activists. In order for blacks to achieve in the United States they had to speak out against institutional inequality and advocate for systems that functioned differently. This only affirms the fundamentally political nature of black medical education.

Although being educated in his own country was an accomplishment, Peck’s degree was not truly functional in the United States because of different levels of exclusion. White people would not hire Peck for his services, but neither would black people so Peck could not find secure practice. The medical community also denied him, with other physicians refusing to recognize Peck’s status as a physician. His experience is representative of that of other black doctors in the late 19th – early 20th centuries. As a result, Peck practiced abroad in Nicaragua, where he died as a casualty of civil war.⁸ Institutions may declare equalities in policy but systemic “changes” do not necessarily have tangible meaning. In Peck’s case, being a licensed American physician did not actually allow him to practice in the United States like his white counterparts. When white institutions failed to educate blacks in the

1 Katherine Kemi Bankole, *Slavery and Medicine: Enslavement and Medical Practices in Antebellum Louisiana* (New York: Garland Pub., 1998), 8-9.

2 Harriet A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial times to the Present*, (New York: Doubleday, 2006), 26.

3 Washington, *Medical Apartheid*, 33.

4 Jim Downs, *Sick from Freedom: African-American Illness and Suffering during the Civil War and Reconstruction*, (Oxford: Oxford University Press, 2012), 22.

5 Downs, *Sick from Freedom*, 33.

6 Morgan, *The Education and Medical Practice of Dr. James McCune Smith*, 603.

7 Michael J. Harris, “David Jones Peck, MD: A Dream Denied,” *Journal of the National Medical Association* 102, no. 10 (2010): 954, accessed October 21, 2014, <http://search.proquest.com.proxy.library.vanderbilt.edu/docview/845240850?accountid=14816>.

8 Harris, “David Jones Peck, MD,” 954.

medical field in any large capacity, black medical schools had to be created. Originally there were seven black medical schools in the United States, but the Flexner Report changed that number.

HISTORY OF THE FLEXNER REPORT

In 1904, the Council of Medical Education (CME) was created by the American Medical Association (AMA) to conduct medical education reform. With the discovery of micro-organisms, bleeding, purging, and alternative philosophies of medicine were recognized as invalid practices. Instead, laboratory experimentation and clinical practice where students applied the scientific method became the educational model that the AMA supported.⁹ In 1908, the CME solicited the Carnegie Foundation for the Advancement of Teaching, a powerful and wealthy organization with institutional power, to lead the survey and reform of medical schools. The president at the time, Henry Pritchett, selected Abraham Flexner, a schoolmaster and education theorist, to conduct the national medical school survey.¹⁰

Flexner traveled to and evaluated all 155 medical schools in the country under five criteria: “entrance requirements, size and training of the faculty, size of endowment and tuition, quality of laboratories, and availability of a teaching hospital whose physicians and surgeons would serve as clinical teachers.”¹¹ His governing philosophy was that quality, not quantity, was necessary to improve the public health of the nation. Flexner identified schools that did not meet his standards of medical education with the intention of closing them. Fewer medical schools meant fewer doctors, but fewer students to teach meant more focused, quality education, and high caliber physicians.¹² After surveying every medical school, the Flexner Report was published in 1910 with evaluations of each and whether or not they should stay open. Prior to the Flexner Report there were seven black medical schools, but after the report was published, the only schools that remained open were Howard University in Washington, D.C. and Meharry Medical College in Nashville, TN.

9 Andrew H. Beck, “The Flexner Report and the Standardization of American Medical Education,” *The Journal of the American Medical Association* 291, no. 17 (2004): 2139, accessed November 17, 2014, doi:10.1001/jama.291.17.2139.

10 Beck, “The Flexner Report,” 2139.

11 Ibid.

12 Steinecke, Ann, and Charles Terrell, “Progress for Whose Future? The Impact of the Flexner Report on Medical Education for Racial and Ethnic Minority Physicians in the United States,” *Academic Medicine* 85, no. 2 (2010): 237, accessed November 17, 2014, doi:10.1097/ACM.0b013e3181c885be.

In Flexner’s report he addresses the medical education of two minorities – women and the Negro. In two pages he explains the “realities” of black medical education per that time, the role he thinks black physicians should serve, and the rationale behind why he closed five of the seven black medical schools. One of the key points from this two-page chapter is Flexner’s favor of black education with the intention of blacks serving other blacks.¹³ It served to the “purpose of protecting whites” from disease because blacks were a potential source of sickness.¹⁴

The negro must be educated not only for his sake, but for ours. He is, as far as human eye can see, a permanent factor in the nation. He has his rights and due and value as an individual; but he has, besides, the tremendous importance that belongs to a potential source of infection and contagion. The pioneer work in educating the race to know and to practise fundamental hygienic principles must be done largely by the negro doctor and the negro nurse. It is important that they both be sensibly and effectively trained at the level at which their services are now important...A well-taught negro sanitarian will be immensely useful; an essentially untrained negro wearing an M.D. degree is dangerous.¹⁵

With an air of benevolence, this excerpt acknowledges African-Americans as individuals with “rights” and an “important contribution” to make to public health. At the same time, blacks needed to know how to medically attend to their own because it was a better alternative than blacks being cared for by “poor white [physicians].”¹⁶ Flexner also wrote that African-American physicians should be trained in the area of “hygiene rather than surgery” with the purpose of serving as sanitarians that civilize those they serve.¹⁷ By saying African-American physicians had a more basic role to play in medicine than white physicians, this chapter simultaneously reflects subordination of African-Americans.

To complicate our understanding of the Flexner Report, the document demonstrates objectivity in addition to racism. Despite racist undertones, objective criteria were used to evaluate all 155 medical schools. These criteria were based on the “best features” of the English,

13 Flexner and Pritchett, *Medical Education in the United States and Canada*, 178-81.

14 Steinecke and Terrell, “Progress for Whose Future,” 238.

15 Flexner and Pritchett, *Medical Education in the United States and Canada*, 180.

16 Ibid.

17 Ibid.

French, and German medical education models. Since Johns Hopkins was an American school operating under an adapted version of European models, Flexner used it as the standard for every medical school he evaluated.

¹⁸ Schools that were not on par with Hopkins, or capable of getting there, received poor reviews and he explicitly named them as schools that needed to be closed.

The disproportionate number of black medical schools failing to meet Flexner's criteria is a symptom of institutionalized racism. Black medical schools had less access to resources than many white medical schools and largely lacked funding because those with money (foundations and wealthy white benefactors) did not choose to invest in black medical schools as they did white schools. Therefore the Flexner Report was a document that reinforced the structure of exclusion of African-Americans from medical education, which had implications for future generations. With only two black medical schools in the country, black physicians were produced in low quantities. Ironically, Flexner acknowledged that there would not be enough black physicians to care for everyone in their race despite the fact that he believed black physicians would provide better care for the African-American community.¹⁹ Such exclusions are important to understand when evaluating the modern African-American health experience and afro-cultural trauma.

AFRO-CULTURAL TRAUMA THEORY

Injury, loss, exclusion, pain – they all stem from trauma that African-Americans have had to experience. When people think about trauma, the first things that come to mind are events or life-threatening experiences that initiate the trauma or post-traumatic stress disorder (PTSD). This “lay trauma theory,” or trauma theory of the masses, allows a very narrow and restricting definition of trauma to persist.²⁰ Lay trauma theory fails to recognize less concrete sources of trauma, which is why cultural trauma theory is necessary. Cultural trauma is “an empirical, scientific concept” defined as, “when members of a collectivity feel they have been subjected to a horrendous event that leaves indelible marks upon their group consciousness, marking their memories forever and changing their

future identity in fundamental and irrevocable ways.”²¹

African-Americans have a unique history of involuntary immigration to the United States that has created a complex collective identity. A key component of cultural trauma that does not align well with that complex identity is the idea that, “traumatic status is attributed to phenomena [that] are believed to have abruptly, and harmfully, affected collectively identity.”²² There was nothing abrupt about the long history of marginalization, exclusion and abuse of blacks in the United States, but that should not exclude phenomena that operate within that system from being considered traumatic. Slavery is the foundation of collective black identity and indeed a “horrendous event”²³ that has changed the future of black identity in “irrevocable ways.”²⁴ The culture of discrimination and oppression of blacks in the United States also produces events with sociocultural processes of trauma in present day medicine and medical education.

Since cultural trauma theory does not capture African-American trauma accurately, I theorize a novel intervention called afro-cultural trauma. Afro-cultural trauma is defined as culturally meaningful phenomena that exclude and harm black collective identity in the United States by silencing and erasing black collective memory. Similar to cultural trauma, afro-culturally traumatic events are made traumatic by the meanings given to them by those that identify with the African-American collectivity. Meaning is as much a part of trauma as concrete events; together they link various types of injury and exclusion. Institutional and structural racism, the meaning of exclusion in medicine, marginalization of blacks in health, marginalization of black doctors, erasure of black collective identity, and erasure of the history of black medical education are all connected by afro-cultural trauma. These phenomena all harm African-American collective identity through a combination of meaning and events.

The collective identity of blacks is harmed by traumatic phenomena as much as it is shaped and defined by traumatic phenomena. The Flexner Report was published in a system that already operated under institutional racism, so it cannot be argued that the Flexner Report is the cause of institutional abuse of blacks or racial health disparities. What can be said about the Flexner Report under the definition of afro-cultural trauma is that the meaning and effects of the document have solidified subordinate power structures for blacks in the United States, silenced

¹⁸ Donald A. Barr, *Questioning the Premedical Paradigm Enhancing Diversity in the Medical Profession a Century after the Flexner Report* (Baltimore: Johns Hopkins University Press, 2010), 62-63.

¹⁹ Flexner and Pritchett, *Medical Education in the United States and Canada*, 180.

²⁰ Jeffrey C. Alexander et al., *Cultural Trauma and Collective Identity*, (Berkeley: University of California Press, 2004), 2-3.

²¹ Alexander et al., *Cultural Trauma*, 1.

²² Alexander et al., *Cultural Trauma*, 9-10.

²³ Alexander et al., *Cultural Trauma*, 1.

²⁴ Alexander et al., *Cultural Trauma*, 60.

black collective memory of the legacy of medical education and shaped the African-American health experience.

The Flexner Report created crisis for African-Americans by contributing to and facilitating destructive sociocultural processes that demand symbolic reparation and reconstruction.²⁵ This crisis had a practical dimension in the exclusion of African-American medical students from white medical schools and subsequently positions of power in medicine. At the same time, there is a symbolic dimension that excluded black physicians and black perspectives from the History of American medicine. History as a proper noun refers to the Eurocentric perspective of history that has been widely accepted as truth written by those in power.²⁶ It systematically silences the voices and perspectives of minorities and the disenfranchised over time, which is reflected in collective memory.

In collective African-American memory, group representation in History both figuratively and literally inform modern experience. That is evidenced by the lack of black representation in medical institutions despite changing social climates that boast of equality and meritocracy. The proportion of black doctors to the black population in the United States was 2.5% in 1910 and as of 2008 that proportion dropped to 2.2%.²⁷ If equality and meritocracy were realities, affirmative action would not be necessary in education and the increased racial and ethnic diversity of health care providers would not be a “pressing national policy priority” for the AAMC today.²⁸

AFRICAN AMERICAN COLLECTIVE IDENTITY IN CRISES

To evaluate the concrete effects of afro-cultural trauma, it is important to look at how health and medical institutions have treated black bodies in the decades since Flexner. From slavery to Jim Crow to present day, the black body has been a source of curiosity, objectified and manipulated by institutions of power in the United States. The Flexner Report ensured that future generations in America would have difficulty intervening with these practices through African-American exclusion from medical institutions making such decisions. This enabled the violation of patient autonomy, beneficence, and justice in the health care of African-Americans. Two sources of injury in the African-American community are violence and collective distrust experienced from events like sterilization of black women and the Tuskegee syphilis experi-

ment.

Sterilization was founded on eugenic theory. Black women were deemed “sexually indiscriminate and bad mothers who were constrained by biology to give birth to defective children.” To prevent black women along with other women of color from reproducing, researchers tested a host of reproductive technologies – one of which was involuntary sterilization.²⁹ Paul Popenoe’s 1935 article on sterilization and eugenics published in the July issue of *The Forum* reflects the attitudes of eugenicists well. According to Popenoe eugenic sterilization “does not unsex the individual” so it is “not a punishment but a protection.” His article argues that eugenic sterilization laws contribute to “social welfare” and this perspective fueled government involvement in sterilization.³⁰ Similar to Flexner, an attitude of supposed benevolence was actually one of bodily subordination.

Forced sterilization threatened the futurity of the black population as a whole. Controlling who is able to reproduce and targeting the black race not only restricts African-American population growth but it attacks a part of self that is formative of the identity of many African-American women – that of a mother. This connects directly to the Flexner Report because surgery was the means by which black women were sterilized and Flexner did not think blacks should perform surgery. Knowing how to perform surgery is a form of power and Flexner’s segregationist view of medicine intentionally aimed to preclude blacks from such power.

Black men were also abused by medical institutions, and the most prominent example is the 1932 Tuskegee syphilis experiment. The United States Public Health Service commissioned a syphilis study with 600 black men in Macon County Alabama. A vulnerable population, Macon County consisted of primarily illiterate sharecroppers living in an isolated, rural town with limited medical resources and low income. Incentives for participants included burial stipends, medical treatment, and free meals on exam days, among other minor things. Of the 600 participants, 399 had syphilis and 201 were control subjects.³¹ At the beginning of the study there was no cure for “bad blood,” another term for syphilis.³² In 1947, penicillin, the treatment for syphilis, was discovered and yet researchers withheld treatment from study participants.³³ In fact,

29 Washington, *Medical Apartheid*, 191.

30 Paul Popenoe. “A Debate on Sterilization Intelligent Eugenics.” *The Forum*, July 1, 1935, 26-28.

31 James H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment*, New and Expanded Edition ed. (New York: Free, 1993), 1.

32 Jones, *Bad Blood*, 5.

33 Jones, *Bad Blood*, 2.

25 Alexander et al., *Cultural Trauma*, 10.

26 Michel Trouillot, *Silencing the Past: Power and the Production of History*, (Massachusetts: Beacon Press, 1995).

27 Steinecke and Terrell, “Progress for Whose Future,” 237.

28 Barr, *Questioning the Premedical Paradigm*, 11-12.

researchers conducted the study for 40 years, studying the effect of syphilis on organs when left untreated.³⁴

Both of these events are prime examples of the legacy of physical abuse of black bodies that has been allowed to persist well into the present. Compulsory sterilization and the Tuskegee syphilis experiment are symptoms of an underlying problem – black lives are not valued. The Flexner Report helped institutionally facilitate this issue through lack of representation of African-Americans in medical institutions. Perhaps substantial black representation in the medical field would change the culture of medical institutions in a way that re-inscribes the black body as one of value. Lack of African-American representation is a legacy of the Flexner Report itself.

Forced sterilization and the Tuskegee experiment were horrors to be avoided by not seeking medical care. It can be argued that such practices led to a survival mechanism for some African-Americans – avoiding medical care to stay alive. That survival mechanism of distrust was then transferred intergenerationally, much like the practices children of Holocaust survivors adopted from their parents.³⁵ Another survival mechanism that has been passed down intergenerationally, thus becoming part of African-American culture, is distrust of physicians.

The sociocultural process shocks and destabilizes structures of meaning, thus revising collective identity³⁶ when events such as compulsory sterilization and clinical research abuse occur. Post-Flexner Report, structures like hospitals, health clinics, and institutions of research took on a different meaning in the face of social advancement. Advancements in civil rights, socioeconomic mobility and education were reflected in rulings like *Buchanan v. Warley* (1917) that prohibited Louisville, Kentucky from refusing to sell property to African-Americans³⁷ or *Brown v. Board of Education* (1954) that desegregated schools. Such changes broke down social norms of black exclusion, which re-defined collective identity as one that maintained equality with whites in aspects of society. As African-Americans gained legal and social recognition of equality in different aspects of society, medical institutions that treated blacks like property with no self-determination

challenged and undermined the equalities African-Americans were gaining. That social pain survives generations through collective memory.

RECONSTRUCTION: MEHARRY MEDICAL COLLEGE

In the early 1900s, special initiatives were created at Meharry to directly improve maternal and infant mortality and venereal disease. By creating those special initiatives, Meharry medical students and physicians helped heal the social pain of neglect and distrust in the Nashville black community. This was not an easy task because there was black prejudice against black doctors stemming from white supremacist assumptions internalized by African-Americans during slavery.³⁸ That prejudice persisted in collective African-American memory post-slavery and into the early 20th century. When the Flexner Report was published and black medical schools began to close, a message was sent to the African-American community that said black physicians were not capable of providing adequate health care. Having internalized “black incompetence” and “only [seeing] white healers when sick,” the relationship between black patients and black physicians was further complicated by distrust³⁹.

Since Meharry medical students were not embraced with open arms by African-American Nashvillians, Meharry’s initiative to support black pregnancy and childbirth did not take off until the 1920s despite its involvement in the outpatient Well-Baby Clinics since 1917. Meharry Medical College got the attention of the African-American community with “the healing of one critically ill baby, brought to the hospital by its mother after she had abandoned hope for its life.”⁴⁰ Following this case, blacks began to *trust* in Meharry medical students and staff, resulting in an increase in patients.⁴¹

Meharry also created the Children’s Venereal Clinic where doctors in training learned to identify the “causes, scope, and effects of congenital syphilis” while serving blacks.⁴² A pioneer in early stage identification of venereal disease, Meharry became extremely efficient at addressing venereal disease before it progressed beyond treatment with the Wasserman Blood Test. All patients seen at the clinic received a Wasserman Blood Test to detect syphilis antibodies and records were kept of syphilis incidence, revealing decreased incidence of syphilis

34 Jones, *Bad Blood*, 211.

35 Carol A. Kidron, “Toward an Ethnography of Silence: The Lived Presence of the Past in the Everyday Life of Holocaust Trauma Survivors and Their Descendants in Israel,” *Current Anthropology* 50, no. 1 (2009): 15.

36 Alexander et al., *Cultural Trauma*, 10-22.

37 Alison Shay, “Remembering *Buchanan v. Warley*,” Publishing the Long Civil Rights Movement RSS, November 5, 2012, accessed November 29, 2014, <https://lcrmlib.unc.edu/blog/index.php/2012/11/05/remembering-buchanan-v-warley/>.

38 Todd Lee Savitt, *Race and Medicine in Nineteenth- and Early-twentieth-century America*, Kent: Kent State University Press, 2007: 276.

39 Savitt, *Race and Medicine*, 276.

40 Summerville and Elam, *Educating Black Doctors*, 74.

41 Ibid.

42 Summerville and Elam, *Educating Black Doctors*, 74.

among blacks in Nashville and the region.⁴³

This directly contrasts to the abuse black men suffered at Tuskegee and serves as an example of the kind of treatment blacks could have received if there were more historically black medical schools to facilitate greater African-American representation in the medical field. The healing Meharry provided was multifaceted. Healing of the body, mind and collective distrust was instrumental for the health, well-being and development of black Nashvillians. Meharry was only one of two African-American medical schools, so the majority of African-Americans in the United States could not directly benefit from services like these. Had other black medical schools existed, perhaps blacks around the country would have benefited from special initiatives and restored trust in medical institutions as well, giving healthcare new meaning that did not harm black identity.

According to Kathleen Stewart, a chronotope is a place where “history has physically merged into the setting” and created “the allegorical re-presentation of remembered loss itself.”⁴⁴ With that, a chronotope expresses feeling, movement and history by bringing it to life.⁴⁵ Meharry Medical College is a chronotope that stands as a symbol of survival in the black community. Meharry re-membered black contributions to medical education and health while striving to heal afro-cultural trauma and social pain through service. The concept of re-membering, “a process of being hit by events” from the past, also stems from Stewart’s work.⁴⁶ The Flexner Report hurt black America by precluding African-American medical contributions from History. Meharry has re-inscribed History with the legacy of black education in several ways, one of which is through the Matthew Walker Comprehensive Health Center. Matthew Walker as a site, a literal place, serves as a representation of the “living” past and a “re-presentation” of loss.⁴⁷

The Matthew Walker Comprehensive Health Center is a private, non-profit health center in Nashville founded in 1968 that began as part of Meharry Medical Center and Hubbard Hospital for family emergency medicine. It has now moved from its original location and grown into four locations in Middle Tennessee, providing primary care, specialty care, dental care and ancillary

services.⁴⁸ The health center was named to commemorate Dr. Matthew Walker Sr., a full professor of surgery and gynecology and chairman of the Department of Surgery at Meharry. He was responsible for the creation of the partnership with Taborian Hospital in the Mississippi Delta that provided Meharry students with residencies and clinical experience in a time where blacks were often denied the already few residency seats available.⁴⁹

CONCLUSION

The Flexner Report of 1910 was a formative document that altered, shaped, and defined the future of the African-American health experience in the United States. Created in a time of blatant African-American subordination and discrimination, the Flexner Report was well-intentioned but had racial implications. The closing of five black medical schools is still playing a role in low African-American representation in medical education and medical institutions today. This research also shows that trauma and medicine have a relationship beyond mental health and PTSD. Afro-cultural trauma is largely sparked by African-American exclusion that consequently harms collective identity and silences collective memory with a dominant, Eurocentric voice.

The unacknowledged meaning the Flexner Report has for the African-American collectivity is a legacy of black exclusion in medical education and erasure of black representation in medicine from collective memory. Trauma facilitated crises such as compulsory sterilization and clinical research abuse at Tuskegee. As a black medical institution, Meharry answered the call for reparation and reconstruction of African-American collective identity. Re-inscribing the African-American health experience with trust and quality care, Meharry is a site of healing for black collective memory that has been systematically silenced. A chronotope, Meharry’s commemoration of Dr. Matthew Walker, Sr. through Matthew Walker Comprehensive Health Center re-members his legacy of achievement in medicine, his commitment to African-American medical education, and his service to the black community.

There is much more healing left to do, but there is hope for equal opportunity in medical education and restored trust in health care services and providers. It is paramount to acknowledge that even benevolent actions have traumatic racial implications that harm a people in a country like the United States with such a deep racial

⁴³ Ibid.

⁴⁴ Kathleen Stewart, *A Space on the Side of the Road: Cultural Poetics in an “other” America*, (Princeton: Princeton University Press, 1996), 90.

⁴⁵ Stewart, *A Space on the Side of the Road*, 91.

⁴⁶ Stewart, *A Space on the Side of the Road*, 90.

⁴⁷ Ibid.

⁴⁸ “Matthew Walker Comprehensive Health Center.”

⁴⁹ Summerville and Elam, *Educating Black Doctors*, 95.

history. Systems of exclusion, erasure, and abuse must be actively dismantled by those in institutional power for true healing to begin.

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