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ESSAY REVIEW I

**AFRICAN AMERICANS AND
HEALTH CARE:
STATE-SPONSORED AND
GRASSROOTS ALTERNATIVES**

Merlin Chowkwanyun

Karen Kruse Thomas, *Deluxe Jim Crow: Civil Rights and American Health Policy, 1935–1954*. Athens: University of Georgia Press, 2011. Cloth \$65.00. Paper \$25.00.

Alondra Nelson, *Body and Soul: The Black Panthers and the Fight against Medical Discrimination*. Minneapolis: University of Minnesota Press, 2011. Cloth \$21.00. Paper \$15.95.

In 2014 and 2015, historians, politicians, and others are commemorating the 50th anniversaries of the War on Poverty, the 1964 Civil Rights Act, and the launching of Medicare and Medicaid programs (1965)—a legislative explosion second only to the New Deal in ambition and lingering public policy consequences for U.S. residents in the 20th century. The resulting balance sheet, however, is mixed, one filled with undeniable victories and glaring shortcomings. Despite the optimism of the early 1960s, by the end of the decade, many observers accentuated the limits of liberal social reform. The 1968 Kerner Commission Report on the urban insurrections famously declared that “our nation is moving toward two societies, one black, one white—separate and unequal.” Reading this report decades later makes one ask: To what extent is that searing line still true, and to what extent is it not? Legalized barriers to public accommodations and employment have fallen, but racialized inequalities of access and outcomes exist in a number of areas.

Health researchers have explored how this inequality manifests itself on bodies, shaping an entire field of inquiry that has blossomed since the 1980s. In the second decade of the 21st century, it is difficult to open up a major public health

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journal without coming across articles documenting glaring racial disparities in a number of areas from health care access to specific disease incidence (with HIV/AIDS perhaps most prominent and tragic) to aggregate mortality trends. These findings have crossed over into the policymaking arena. Racial health disparities are prominently featured in *Healthy People*, the federal government's decennial population health report, and the major philanthropic foundations in the health sector have expanded their grant-making efforts and long-term programming to address the issue.¹ What was once a marginal area of interest has quickly become central to academic research and policymaking around health.

But there are signs that this research might be reaching a point of decreasing returns. Scholars have identified a range of mechanisms that might be responsible for racial health disparities, including discriminatory behavior by practitioners; day-to-day accumulated stress from anti-minority animus; unequal access to a variety of health services; and differential environmental health burdens, to name just some. The models that capture how these mechanisms work, at what levels (from individual to societal), and via what causal pathways, grow more complex. Situating them in a longer-term institutional and policy context, however, has been less successful. As one group of seasoned researchers put it, much of the work, largely by omission, "discounts the very important role of human and institutional agency. . . . [W]e have come only so far in learning how to isolate the effects of a single aspect of the environment from the multiple confounding effects of the social system in which it is embedded."²

For historians, this explanatory vacuum is an opportunity to inject a perspective often absent from the research on health disparities, and indeed, many have taken up the task. The past decade or so has witnessed the publication of stellar monographs exploring how racial ideology and racist practice, from the antebellum era through the present, have resulted in unequal aggregate health experiences and outcomes, especially for African Americans. Taken as a whole, this extraordinary literature disrupts celebratory narratives of the American public health enterprise, all too commonly and unthinkingly embraced by present-day practitioners and researchers, and instead highlights how central and integral racialist ideas and practices were to current developments.³

Karen Kruse Thomas's *Deluxe Jim Crow: Civil Rights and American Health Policy, 1935–1954* and Alondra Nelson's *Body and Soul: The Black Panther and the Fight against Medical Discrimination* are two welcome additions to this scholarship, and they will do much to help us understand various policies and movements that have attacked racial health disparities. They also move in directions less developed by the previous race-health literature, strong as it is. Thomas focuses on formal policymaking, specifically the phalanx of influential philanthropic organizations, federal and state legislatures, and governmental agencies that

worked to develop the woefully lacking health-care infrastructure in the American South. Nelson shifts our attention to social movements around health through an examination of the Black Panther Party's various health programs. More broadly, the works close a gap between histories of health reform and civil rights, which tend to be studied separately, even though the concerns of one permeated the other. It was not by chance, after all, that Medicare and Medicaid passed only a year after the 1964 Civil Rights Act.

By "deluxe Jim Crow," Thomas refers to a program of investment in the Jim Crow South that potentially bettered the lives of southerners—black and white—while carefully avoiding any direct challenge to legally sanctioned segregation in the pre-*Brown v. Board of Education* era. The book documents how this program developed in the decades following *Plessy v. Ferguson* (1896), beginning in the early Progressive era. Philanthropic foundations, most prominently the Rosenwald Fund, drew attention to health deficiencies in the region and funded various pilot programs, including the training of black public health nurses and the upgrading of infrastructure. These private initiatives led to government interventions at both the federal and state levels, many catalyzed by the new Social Security Act appropriations. Results were swift and pronounced: the creation of new state and city health departments, even more training of health personnel, improved health-needs surveys, and better collection of vital statistics. *Deluxe Jim Crow's* chapters alternate between broader national trends and statewide activities in North Carolina, a clever and useful way of demonstrating national and local dynamics in health policy development.

Maternal and child health benefited especially from this new activity. Thomas notes that between 1930 and 1940 there was a four-fold increase in maternal and child health spending by state governments. Much of it aided construction of prenatal and well-baby clinics that provided basic medical examinations and increases in supervised deliveries and vaccination. More formal training of midwives also occurred, though hardly free of contradictions when it came to older black midwives, some of whom saw (not without reason) the initiatives as encroachment on traditional ways of healing. Black midwives also faced other racist barriers to licensing such as high school graduation requirements, as well as condescending attitudes from white medical professionals. These manifestations of "deluxe Jim Crow" fill Thomas's text. A central question is why and how it continued before the first signs of legal segregation's downfall.

It was in hospital construction, however, that the paradox of Jim Crow's co-existence with improvements in southern health played out most dramatically. Thomas offers a thorough and richly detailed account of the mid-century hospital boom in the United States. Most historical accounts focus heavily on the Hill-Burton Hospital Survey and Construction Act (1946), but Thomas shows that in

the South, Hill-Burton is best seen as an outgrowth of trends that began at least a decade and a half earlier. New Deal public works programs aided hospital construction and improvements in facilities in several southern states, though this was more scattered before the hallmark 1946 legislation. Nonetheless, these early projects were not inconsequential. Louisiana, for example, constructed four charity hospitals, including one in New Orleans, the second largest in the country at the time. Beds allocated to African American patients increased by 68 percent in North Carolina, and by 82 percent in Virginia between 1940 and 1950.⁴

Still, hospital spending in the aftermath of Hill-Burton dwarfed these earlier activities. One reason was timing. Hill-Burton, Thomas rightly argues, generated wide political appeal because politicians saw hospital construction as an acceptable alternative to national health insurance proposals in the 1940s. Proponents of the Wagner-Murray-Dingell Bill calling for national health insurance were vulnerable to histrionic red-baiting as well as the hostility of the American Medical Association, whose members viewed it as a threat to a private fee-for-service system and used their substantial political power to oppose the legislation.⁵ But the Hill-Burton Act passed during a mid-century boom in biomedical spending and institutional expansion in the form of academic medical centers and the creation of the National Institutes of Health. The legislation significantly favored the South and “by mid-1949, the eleven former Confederate states had received 93 percent of federal Hill-Burton appropriations” (169). Even as this percentage fell over time, the South’s share still remained a substantial 40 percent in 1962.

Thomas’s chapter on Hill-Burton’s implementation in North Carolina shows the on-the-ground effects of top-down federal policy. The funds, matched by the state, led to the growth of various types of facilities, including the construction of eighty-six public health centers and the expansion of the University of North Carolina’s School of Medicine. Hospital construction and the enormous increase in the total number of beds—115 percent in the first two decades after Hill-Burton’s passage—went the furthest in attacking the inter-regional inequalities in health services. Among all states, Thomas reports that North Carolina came first in number of hospitals constructed with Hill-Burton funds, fifth in total money spent, all of which resulted in 7,660 total beds being made available between 1947 and 1954 alone.

Of course, all of this expansion occurred within the confines of a racialized 20th-century U.S. welfare state, whose contours have been defined in the works of Michael K. Brown, Jill Quadagno, Robert Lieberman, and Ira Katznelson.⁶ Most African Americans were excluded from the most generous New Deal and Fair Deal era programs, from Social Security to Federal Housing Authority loans

to the GI Bill.⁷ And because of employment discrimination, they did not benefit greatly from private employer-provided medical programs. Moreover, federal administrators frequently delegated the actual provision of welfare relief and health benefits to state and local governments that distributed it in discriminatory fashion. Hill-Burton supported infrastructural improvements, but it also led to the proliferation and entrenchment of Jim Crow facilities.

Thomas's analysis on this issue is simultaneously admirable yet disquieting. Her account is admirable because it could have easily been a relentless documentation of segregated health care in the 20th-century South, serving primarily as historical exposé. Instead, Thomas carefully identifies varying degrees of segregation and the different rationales behind them. Although many facilities were all-white or all-black, an increasing number admitted both black and white patients, then placed them in separate wards within the same facility. This was hardly full desegregation, but it was in the eyes of some contemporaries an improvement and the only realizable reform at the time. Provisions within Hill-Burton enforced racially proportionate construction, at least in theory. Thomas's handling of varying positions within southern white progressive, black medical professional, and civil rights circles is nuanced and free of anachronistic projections. In essence, the question was: "Should blacks continue to pursue equalization that would bring them immediate benefits, or should they fight for full integration in government health programs?" (3). To many people critical of the racialized social order, breaches in the walls of legal segregation might eventually contribute to the downfall of the Jim Crow edifice itself.

It is sometimes difficult to tell what Thomas herself makes of the latter position, but ultimately, she seems to make it her own. At several points Thomas explicitly links "deluxe Jim Crow" to the post-*Brown* phase of the Civil Rights Movement and the fight for full integration, declaring, for instance, that "by the 1950s, deluxe Jim Crow policy had considerably weakened the legal basis for segregation, which ideally positioned the direct-action civil rights movement to deliver a series of rapid and devastating blows" (5). Elsewhere, she notes that "one of the signature features of deluxe Jim Crow policy was its generation of unintended consequences, particularly the gradual undermining of segregation and empowerment of minorities as both recipients and shapers of federal health programs" (48). At one point, she argues that biracial, but racially separate facilities, "made the transition to full integration in health care much smoother than was the case in education" since they "promoted more interracial contact among black and white health professionals than was possible among educators" (268). Thomas concludes that "though never fully realized, federally sponsored racial and regional equalization in health policy transcended the limits imposed by white policy makers and ultimately lay the foundation for eliminating formal racial barriers in the

health-care system” (178). For Thomas, then, “deluxe Jim Crow” health policies were mitigated by a “Trojan horse” quality that “unwittingly released forces that would dramatically accelerate the civil rights movement” (178). Even if administered in a segregationist context, they no doubt brought health resources to many black southerners who might otherwise have missed the mid-century biomedical revolution entirely. Thomas’s emphasis deviates from that of the earlier race-welfare scholarship, which has focused on these policies’ central role in creating intergenerational inequalities.⁸

It is also why, after reading *Deluxe Jim Crow*, I felt some general disquiet and unease, despite being impressed by the breadth and the sophistication of a narrative that required the author to keep a careful eye on multiple sites of policymaking and implementation. It is one thing to avoid anachronistic and morally easy condemnations of Jim Crow public administration in its various manifestations. But in attributing to “deluxe Jim Crow” health policy a substantial role in the eventual dismantling of Jim Crow, Thomas at times borders on a rehabilitation effort that I do not find warranted.⁹

This depiction is unconvincing for several related reasons. Thomas characterizes the post-*Brown* moment as an outgrowth of a foundation laid by the gradualist approach of “deluxe Jim Crow.” This goes against much of the civil rights historiography, which portrays accommodationism as an increasingly futile strategy, one that eventually *gave way* to, rather than supported or laid the groundwork for, as Thomas would claim, top-down and aggressive “big stick” federal intervention in the form of Supreme Court rulings, presidential executive orders, the withholding of federal funds from states and localities in noncompliance, and military action. There are points where Thomas implicitly acknowledges this, but only fleetingly. Major federal cases make cameo appearances: *Brown* (1954) most obviously, but also the lesser known *Sipuel v. Oklahoma State Board of Regents* (1948), *Sweatt v. Painter* (1948), and *Simkins v. Moses Cone Hospital* (1963). But their impact, and that of activists who firmly rejected accommodationism and pressured federal forces from without, is minimized compared to Thomas’s repeated assertions about the supposed causal role played by “deluxe Jim Crow” in abetting the fall of legal segregation from within.

I would argue that “deluxe Jim Crow” arose during the growing discontent with accommodationism; real, if often stillborn, federal interventions; mounting legal decisions unfavorable to the Jim Crow regime; and the international Cold War spotlight; and it should more accurately be characterized as the defensive last hurrah of Jim Crow politics, not as a successful transitional program to full desegregation. Even after legal desegregation, there were immediate problems of enforcement, often against fierce racist obstinacy. There again, it was federal intervention, not implosion from within, that broke the back of Jim Crow. This was

similar to what happened after the passage of Medicare in 1965 when the Department of Health, Education, and Welfare withheld funds from hospitals, school districts, and other facilities until they fully complied with civil rights laws.¹⁰

Whatever the positive material benefits from a softened segregationist regime, it was still segregation in the end. Thomas exhibits a degree of moral quietism here, yet “deluxe Jim Crow” by the 1940s had few supporters. Howard University historian Rayford W. Logan’s important volume *What the Negro Wants* (1944) presented the views of fourteen black leaders and spokespersons, intentionally selected because they ran the political spectrum. Yet they all ended up calling for an end to legal segregation, leading the editors at the University of North Carolina Press to threaten not to publish the book. Thomas occasionally discusses integrationist objectives and *What the Negro Wants* is mentioned once, but her narrative has a surprising normative thinness. She is sympathetic toward southern white progressives who were put on the spot by advocacy of integration, but at one point glibly refers to “full and uncompromised integration” as a “wonder drug” (174). While a Baltimore black newspaper originally coined the phrase “deluxe Jim Crow” in 1927, and subsequent civil rights figures used it pejoratively to mock and “decry” halfway desegregation measures, Thomas uses it as an anchoring concept of the book.

Finally, there are empirical questions that cast doubt on some of Thomas’s bolder claims about what “deluxe Jim Crow” truly delivered. In one extended passage, Thomas reviews present-day racial health disparities and disproportionate minority representation among the uninsured, infant mortality, and syphilis, respectively. She notes that the figures have (at best) stayed stubbornly the same and (at worst) have actually grown more severe in the post-1964 moment, writing of “racial disparities that began in the early twentieth century, receded at midcentury, and *accelerated* again after integration.” This leads her to conclude that “one major reason that the problem of significant racial disparities . . . persists into the twenty-first century is that legally *sanctioned segregation, despite its myriad deleterious social and psychic effects, was not the principal cause of racial disparities in health*, nor was access to medical care the primary determinant of life expectancy during most of the twentieth century.” She continues: “Consequently, the *greatest narrowing of twentieth-century health disparities was achieved not after the integration of health care in the mid-1960s, but under deluxe Jim Crow health policy. . . .*” (italics added; 264–65).

These are ambitious and sweeping claims, but I am not sure the clarity of concept and adequate data are there to support them. At the conceptual level, Thomas does not distinguish between *gaps* on the one hand, and *aggregate improvement* on the other. It is entirely possible for a racial gap on a health indicator—the basis

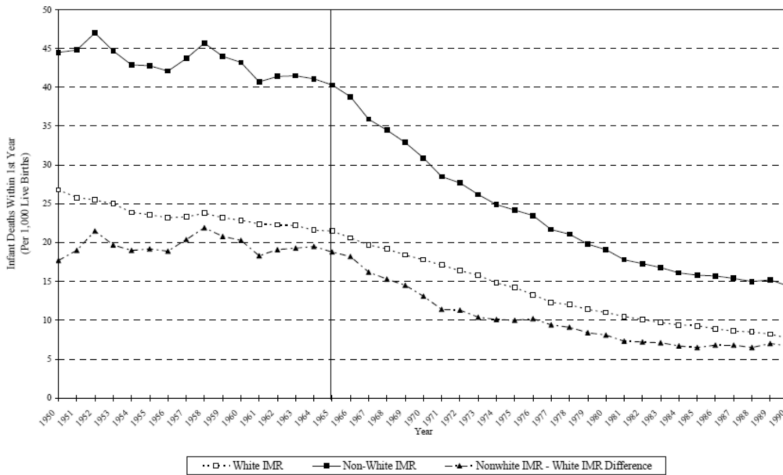
of Thomas's claims—to persist or expand from time T_1 to time T_2 , even as members of *both* racial groups experience aggregate improvement on the health indicator in question.¹¹ Such trends can occur for a variety of reasons: better overall conditions conducive to well being in T_2 (like the end of legal discrimination) nevertheless co-existing alongside persistent advantages and disadvantages experienced by racial groups on respective ends of the disparity. A gap's persistence or expansion in T_2 is not a license to view T_1 in a favorable light, especially if aggregate improvement still occurred across the racial board despite a persistent gap. Rather, these trends are an invitation to consider new and unexpected challenges in T_2 that continue to prevent the elimination of racial disparities: in the post-segregation era, this includes everything from mass incarceration, ongoing job discrimination, day-to-day racial animus, unequal access to health services, and other determinants that the literature cited at the start of this essay has identified in some detail.

To claim one epoch had a more positive effect on health outcomes than another, one needs to identify potential causal mechanisms to explain the variation. Thomas does not do so, nor offer much data to support potentially incendiary claims that might be misappropriated by those seeking to tarnish the civil rights victories, however imperfectly realized. An alternate approach—and one at odds with Thomas's argument—is a recent widely read analysis by economists Douglas Almond, Kenneth Y. Chay, and Michael Greenstone. They argue that the fall of Jim Crow ushered in a new era of enormous and immediate improvement in black infant mortality, measured by *both* the infant mortality rate itself *and* the narrowing of the racial gap. The authors identify hospital desegregation as the chief mechanism and a decade-long decline in *post*-neonatal mortality rates as the driving force in the overall decline. Marshalling death records from a number of sources to make their case, along with careful analysis of pre/postnatal trends after the implementation of strict federal Medicare eligibility requirements that eliminated holdout vestiges of segregation, they found a decline in the black infant mortality rate that “exceed[s] the decline in the white IMR [infant mortality rate]. . . . They also report that this “disproportionately occur[s] in the areas of the country where segregation and inadequate supply were more pervasive . . . that are more responsive to access to hospitals. . . .”¹² They conclude that the “trend break” in black infant mortality rates “in the rural South was driven by federally mandated desegregation efforts that increased access to hospital care for black infants (see figure 1a).”¹³

A last empirical point: When it comes to material conditions and quality of care, it is hard to discern how the final assessment for “deluxe Jim Crow” ought to be read. We have scattered evidence of what biracial wards were like, but a clear overall picture never quite comes through.¹⁴ In the end, though, this may be a moot

point given the aforementioned normative dilemmas. Even if it provided equal or acceptable treatment from time to time, separate but equal was still separate and on increasingly shaky moral ground by the mid-century. Yet, these reservations aside, there is no doubt that Thomas has performed a major service with this book, one of the most exhaustively researched accounts of 20th century American health policy to date.

Figure 1a: Trends in the Infant Mortality Rate by Race, 1950–1990



Source: Douglas Almond Jr., Kenneth Y. Chay, Michael Greenstone, “Civil Rights, the War on Poverty, and Black-White Convergence in Infant Mortality in the Rural South and Mississippi,” MIT Department of Economics Working Paper Series (2006), 8.

“Deluxe Jim Crow,” according to Thomas, was the apex of reform efforts centered on geographically and racially based health inequality. “In the decades that followed,” she argues, “race and region virtually disappeared as categories of analysis in health-care policy and political debate, even during the tumultuous Great Society years. Health care was largely absent from the 1960s civil rights agenda” (264). This certainly would be news to the community health workers who set up the first federally funded neighborhood health centers in Mound Bayou, Mississippi, the Lower East Side of New York City, and the post-riot neighborhoods of Watts, Los Angeles, and Hough, Cleveland, throughout the decade. The claim would befuddle members of the Medical Committee for Human Rights (MCHR), a group of physicians who provided “medical presence” during some of the most pitched and violent moments in the Mississippi Freedom Summer campaigns and their immediate aftermath. Thomas’s view would also amaze activist medical students who demanded that their campuses stop insulat-

ing themselves from the hyper-segregated, poverty-stricken neighborhoods where they were often located. And it would surely raise the eyebrows of the figures examined in Alondra Nelson's *Body and Soul*, a prize-winning analysis of the Black Panther Party's (BPP) multi-faceted health programs in the late 1960s and early 1970s.

For whatever reason, health-care issues, despite being intertwined with other parallel movements of the time, have remained off the historiographical radar until recently. *Body and Soul* will be a touchstone for future scholars working in this small but burgeoning area of research. Even those with little interest in health politics at the grassroots level will profit from reading it, deepening their understanding of the Panthers, civil rights activism and Black Power, and larger themes in the sociology of science.

The BPP is frequently caught between two unsatisfying modes of writing. At one extreme are hagiographies, influenced in no small part by the BPP's own talent for spectacle and theater—at the other, cynical hit pieces, wherein the party becomes a metonymic symbol for all the perceived excesses of 1960s radicalism. Nelson is keenly aware of both these impulses. By turning instead to sites of activism that drew less public attention (both at the time and now), she avoids writing what could have been a narrow and celebratory book, and instead connects the Panthers to a number of larger themes: neighborhood-level social service, patient activism, and racist assumptions in mainstream science. As intrinsically interesting as the party is on its own, *Body and Soul* becomes a book about more than its immediate subjects.

A key strength is its sophisticated conceptual approach, developed in the book's introduction and opening chapter. Here, Nelson lays out an African American health politics that spanned the 20th century and took different forms depending on the era. The chapter uses a number of historical examples, and many readers will find the survey handy to assign in courses on black health politics. Following the “nadir of race relations” immediately following *Plessy*, African Americans founded health institutions of varying ideological stripes. They included National Negro Health Week, whose origins lie in the “Tuskegee Machine,” the Garveyite United Negro Improvement Association's Black Cross Nurses, and black hospitals and public health campaigns. But this institution building co-existed alongside regular engagement with the U.S. public health state. The United States Public Health Service (USPHS) took over National Negro Health Week in the 1930s, and African American health professionals fought long and hard against the segregation of professional societies and facilities. Even as they built parallel autonomous institutions, Nelson points out that they simultaneously “pushed for comparable and shared facilities and services for black and white medical practitioners” and “full inclusion in the healthcare state” (25).¹⁵ This is important for

understanding the Panthers, for their health activities often transcended neat categories—“separatist,” “nationalist,” “integrationist,” among others.

Even as the Panthers set up independent programs and institutions, they often relied on white medical personnel, lobbied rarefied medical organizations, and accepted government funds. In contrast to other oppositional movements to organized American medicine at around the same time, “the Party,” writes Nelson, “did not reject medicine outright; rather, it sought to provide and model respectful and reliable medical practice” (79). This was less an overt contradiction than a continuation of a decades-long practice: building one sphere, while fighting for recognition and equality in another. And it extended beyond just the delivery of health-care services, but into medical science itself. Since at least the late 19th-century rise of anti-black eugenic theories, Nelson argues, African American scholars mounted a steady critique of racist biological and medical science through an ongoing effort to “recontextualize” racist paradigms and the construction of a “scientific counterdiscourse.” Nelson sees various campaigns of the BPP as manifestations of a “politics of knowledge” against scientific racism.

All of the above showcased the Panthers’ “social health” perspective, one that saw bodily ills as inextricably bound up with larger social determinants that transcended individual biology itself. The heart of *Body and Soul* consists of three chapters examining how social health was actually instantiated. The chapters cover free clinics, campaigns to raise political awareness of sickle cell anemia’s prevalence among African Americans, and protests against racist assumptions in the emerging neuroscientific arena.

The Panthers’ free clinics opened during a flurry of health reform whose flash-points included Medicaid and Medicare, but also the federal Office of Economic Opportunity (OEO) neighborhood health centers program, some still in existence. The OEO was one of many social service programs in the War on Poverty that by the mid-1960s legally mandated laypeople’s “maximum feasible participation” in the administration of programs receiving federal funds. In actual practice, determining what exactly that meant, and who could legitimately invoke it, was often anybody’s guess, and fierce battles around governance were recurrent throughout the era. For Nelson, one impetus for the BPP forming its own clinics—in 1970 it mandated that all chapters do so—was frustration over how much grassroots input could be realized within top-down bureaucratic mandates. But it also grew from a suspicion of contemporary medical practice itself, namely the disrespectful treatment of African Americans at institutions that were then predominantly white—or simply the absence of health resources altogether. As the organizers of the Panthers’ People’s Free Medical Clinic in Berkeley put it, “We know that as long as the oppressor controls the institutions within our oppressed communities, we will be subjected to institutionalized genocide whether it comes from inadequate

housing, the barrel of a pig's shotgun, or from inadequate medical attention. . . . [We] must create institutions within our communities that are controlled and maintained by the people" (77).

Nelson's analysis of the clinics resembles an ethnographic account that captures both the day-to-day experience and its occasionally improvised quality. Panthers scrounged for equipment, sometimes with the aid of black and white local physicians with access to medical resources. Most of the facilities were able to offer basic primary care, staffed by volunteer physicians, but also a non-professional "health cadre," mostly women, who developed protocols of interaction between the patients and professionals. Indeed, patients were actively encouraged to call out the clinic staff when they showed signs of professional hubris. The BPP also saw the patient as part of a broader social context outside clinic walls. One novel program was a patient advocate system whereby those needing specialty services beyond the basic ones at the clinic were directed by staffers through the often labyrinthine health-care system at large. Altogether, the clinics amounted to a lived critique of a racialized hierarchy in the medical profession and a narrow biomedical focus antithetical to a social health perspective.

For all their strengths, though, the clinics also exhibited some severe limitations. Reading through the activities of various sites does beg the question of how big a dent free clinics, however perfectly run in each locality, could make in the flawed structures of the American health-care system. Relying on volunteers and donations of supplies made for practices that were, in the end, rather shoestring. In fact, many people involved in the clinics recognized the problem, and one fascinating episode involves internal debates about whether to accept government funds to sustain the projects. Nelson herself is ultimately aware of the dilemma, noting that "because the health activist tactic of institution building is especially resource demanding, requiring both outlays of capital and access to (trusted) expert collaborators, the Party's clinic program was a mixed endeavor" (112). But the inherent constraints on prefigurative medical experiments are sometimes more implicit than explicit in both Nelson's account and the Panthers' own claims about what they were accomplishing.

Body and Soul's concluding chapters detail the Panthers' activism around sickle cell anemia awareness and against a UCLA neuroscience project formed in the wake of 1960s urban rioting. These sections on the "politics of knowledge" effectively demonstrate how the party's health program, in keeping with a social health perspective, went far beyond the sphere of medical care. Sickle cell attracted the Panthers' attention after critics pointed out the comparative dearth of federal research funds that went towards its study, a gap that carried much symbolism given sickle cell's disproportionate prevalence among certain ethnic groups.¹⁶ Sickle cell activism served as a metaphor for medical neglect, and the party's

campaigns included screenings and educational programs that brought rarefied medical knowledge about the understudied condition to those it potentially affected the most. Highlighting neglect, in turn, was a way of rebutting racist and essentialist claims about congenital black bodily inferiority. The latter are the main subjects in Nelson's account of a center at UCLA, whose intellectual leaders sought to find explanations for "violent behavior" in the physiology of the brain. Although the racial claims in the "Violence Project" were not always explicitly spelled out, they were clear enough for the party to mount a campaign that drew significant public attention and eventually closed the center. Nelson's account of this important episode can be read alone, and it is necessary reading for anyone concerned with the resurgence in biologically reductionist claims, many with similar racial inflections.

Body and Soul is an enormous achievement. Finishing it, I wondered how to position the BPP health program within the matrix of radical and liberal social reform during the era of the War on Poverty. The Panthers were master rhetoricians, and as political entrepreneurs, they had an obvious stake in accentuating the vanguard quality and revolutionary distinctiveness of their work. But in choosing to focus on the BPP health program—and away from the general revolutionary claims that have preoccupied most students of the organization—Nelson highlights more affinities between the BPP and various liberal and left-liberal counterparts than her subjects would have acknowledged. It is true, for example, that many of the OEO neighborhood health centers' mechanisms for "maximum feasible participation" amounted to little more than *pro forma* tokenism. But there were other examples where shared medical governance did occur, even in imperfect ways. Though their architects often employed much more sedate rhetoric than the Panthers, many of the signature War on Poverty health programs shared the same goals: bringing health care to locales where it was absent, flattening medical hierarchy, and practicing a medicine aware of the social context in which it was embedded. Much of the BPP's famous "Ten Point Program," when one puts the revolutionary rhetoric aside, amounts to a sober call for access to improved standards of living. In the sickle cell and UCLA episodes, the Panthers were willing to work with researchers and attorneys who shared their concerns, and though these alliances sometimes resulted in liquidation of the BPP's larger social health paradigm (especially in the sickle cell case), they were also often surprisingly fruitful and legitimized the Panthers' critique in the broader public sphere, as in the case of the Violence Project.

This is not a criticism of Nelson's book so much as it is a call to bridge it with a new generation of work on liberal policymaking and activism of the period, collected to great effect in Annelise Orleck and Lisa Hazirjian's recent volume, *The War on Poverty: A New Grassroots History, 1964–1968*.¹⁷ As scholars have begun

to question the stark boundaries between the mainstream “civil rights campaigns” and “Black Power,” they might throw into the mix “liberal” and “radical.” In the overlapping eras of civil rights activism, Black Power, and the War on Poverty, scratch a radical, find a liberal; scratch a liberal, find a radical. *Body and Soul* is a major contribution to understanding an era that still confounds us.

NOTES

¹For *Healthy People*, see various material at <http://www.healthypeople.gov>.

²Nancy Adler, Christine Bachrach, Dorothy Daley, and Michelle Frisco, “Building the Science for a Population Movement,” Institute for Medicine (IOM) Roundtable on Population Health Discussion Paper, 4. See <http://http://www.iom.edu/~media/Files/Perspectives-Files/2013/Discussion-Papers/BPH-BuildingTheScience.pdf>.

³I review some of this literature and its relationship to the scholarship on disparities in “The Strange Disappearance of History from Racial Health Disparities Research,” *Du Bois Review* 8, no. 1 (2011), 253–270.

⁴Karen Kruse Thomas, *Deluxe Jim Crow: Civil Rights and American Health Policy, 1935–1954* (Athens, GA, 2011). Page numbers for quoted material are placed in parentheses in the text.

⁵An account of this milieu is in Jill Quadagno, *One Nation, Uninsured: Why the United States Has No National Health Insurance* (New York, 2006), ch. 1.

⁶Michael K. Brown, *Race, Money, and the American Welfare State* (Ithaca, NY, 1995); Jill Quadagno, *The Color of Welfare: How Racism Undermined the War on Poverty* (New York, 1994); Robert C. Lieberman, *Shifting the Color Line: Race and the American Welfare State* (Cambridge, MA, 1997); Ira Katznelson, *When Affirmative Action Was White* (New York, 2005).

⁷Harvard Sitkoff, *A New Deal for Blacks: The Emergence of Civil Rights as a National Issue, The Depression Decade* (New York, 1978); and Louis Lee Woods, “‘Almost No Negro Veteran . . . Could Get a Loan’: African Americans, the GI Bill, and the NAACP Campaign against Residential Segregation, 1917–1960,” *Journal of African American History* 98 (Summer 2013): 392–417.

⁸See Brown, *Race, Money, and the American Welfare State*; Quadagno, *The Color of Welfare*; and Lieberman, *Shifting the Color Line*.

⁹*Deluxe Jim Crow* follows the recent publication of a similarly toned biography of Booker T. Washington by Robert J. Norrell, *Up From History: The Life of Booker T. Washington* (Cambridge, MA, 2011).

¹⁰See, for example, “Integrate or Get Nothing,” *U.S. News & World Report*, 3 May 1965.

¹¹David Mechanic discusses implications of this measurement problem further. See David Mechanic, “Disadvantage, Inequality, and Social Policy,” *Health Affairs* 21 (March 2002): 48–59.

¹²Douglas Almond, Jr., Kenneth Y. Chay, and Michael Greenstone, “Civil Rights, the War on Poverty, and Black-White Convergence in Infant Mortality in the Rural South and Mississippi,” MIT Department of Economics Working Paper Series (2006), 8, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=961021.

¹³*Ibid.*, 1. Almond et al.’s study is not, of course, the last word on the question. But if one wants to make claims about the relative merits or demerits of “deluxe Jim Crow” and the era after it, their methods and evidence are the sort one must gather.

¹⁴This leads to more than a few tentative and ambiguous passages such as: “The conventions of segregation were at times indistinguishable from the hospital staff’s expectations of unquestioning submission to medical discipline and routine. For example, regardless of race, patients were commonly called by first or last name without courtesy titles, although this practice apparently persisted longer in southern Jim Crow wards.” See Thomas, 75.

¹⁵Alondra Nelson, *Body and Soul: The Black Panther Party and the Fight against Medical Discrimination* (Minneapolis, MN, 2011). Page numbers for quoted materials are placed in parentheses in the text.

¹⁶I say “certain” here because sickle cell anemia has become widely and mistakenly characterized as a race-specific “black disease,” even though it is present among several population groups around the world, including plenty of people who would not be classified as “black.” Indeed, it is geographic concentrations of sickle cell trait that determine patterns in population distribution—not “race.” For a broader discussion of this fallacy and biological essentialism in medicine more generally, see Lundy Braun, Anne Fausto-Sterling, Duana Fullwiley, Evelyn M. Hammonds, Alondra Nelson, William Quivers, Susan M. Reverby, and Alexandra E. Shields, “Racial Categories in Medical Practice: How Useful Are They?” *PLOS Medicine* 4 (25 September 2007), e271. A fruit-

ful tension in the Panthers' advocacy—to which Nelson is very attuned—is whether their political invocation of sickle cell anemia ended up reinforcing racially essentialist ideas that they hoped to rebut. This is an issue well worth exploring by scholars.

¹⁷Annelise Orleck and Lisa Hazirjian, eds., *The War on Poverty: A New Grassroots History, 1964–1968* (Athens, GA, 2011).