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Schools of Rivals: Physicians, Fights, and Reform in Nineteenth-Century, Southern Medical Education

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Schools of Rivals:
Physicians, Fights, and Reform in Nineteenth-Century, Southern Medical Education

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy in History

by

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Abstract

While the professionalization of medicine in the nineteenth century hinged on community trust, faculty at Southern medical schools hurt their own reputations with their proprietary schools, their public rivalries, and their competition for clinical material and cadavers. Attempts to regulate medical schools also became fodder for doctors to slander each other, all arguing that their methodologies and their schools were superior. This fierce competition resulted from the constant need to lure in more students to ensure these schools' survival, but it hurt the reputation of doctors as a whole, convincing the public that one doctor seemed just as incompetent and quarrelsome as another. The competition for cadavers also damaged the relationship between African Americans and medical schools. The Flexner Report, published in 1910 by the Carnegie Foundation, exposed flaws in these schools which required money and state absorption to fix, and many schools did not survive the obstacles that they themselves had exacerbated.

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Acknowledgements

Oscar Wilde once said, “We are all in the gutter, but some of us are looking at the stars.” Unlike most of Wilde’s pithy sayings, this one was not spoken in conversation but appeared as a line of dialogue in the 1892 performance, *A Play About A Good Woman*. I have thought about this line many times over the course of my life, and none more than these last few years. That is likely because, as many people in graduate school know, the gutter is often where you write your dissertation. These pages have been the product of long nights and hard days, and though they say much about medical education, they say nothing of the trials that I went through producing them. I lost my loving grandparents, Libby and Lewis Laningham, to age, my caring aunt, Kathy Chapell, to an unexpected illness, and countless hours of time during this pursuit. Family emergencies, sicknesses, and cross-country moves weighed heavily on me as well as a global pandemic. I’m sure that all academics can relate to this at some point in their lives. Yet before I leave readers with the idea that all was bad, I want to mention in the acknowledgements of this work the many people who climbed down in the gutter to remind me daily that the stars still existed. I want it known that without any one of the names about to be mentioned that this study would never have happened, and it certainly wouldn’t have been completed. I am a historian because of these people.

Though I can’t mention everyone who has helped me as there are too many to count, I want to start from the beginning with all the archivists who directly made this research possible. Tim Nutt, April Hughes, and Suzanne Easley were the staff over the Historical Research Center at the University of Arkansas Medical School, and without them, I never would have settled on a dissertation topic. They encountered me when I was young and new to research, but they loved me like a family. Each one of them will always have a special place in my heart. Stephanie M.

Lang at the Kentucky Historical Society and Mary K. Marlatt at the Kornhauser Archive were my first experience with research in Kentucky, and each of them were willing to do anything in their power to help me find sources on medical schools there as well as encourage me in my study. B. J. Gooch and Jamie Day at Transylvania University not only pulled collections for me and took me on a tour of their historical medical museum, they provided joy and laughter at a point when spirits were low and the project seemed overwhelming. Likewise, Beth Lander at the Mutter in Philadelphia made me feel immediately welcome in a city that otherwise would have been daunting to navigate. I had many fellowships from the Wood Institute, the Kentucky Historical Society, the Filson, and the Society for the History of Medicine and Health Professions that all made this work financially possible.

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My friends saw me through the worst moments of this process and persuaded me to believe that life existed outside of looking at documents that were over a century old. Michelle King and Anne Marie Martin were my pep squad, cheering me on from day one. I wish both of you the best that the world has to offer, because I know no one more deserving of happiness. My

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The last couple of years of my time writing took place at Tennessee Tech University while I worked as an instructor. I could not have hand-picked a better department to work with. Elizabeth Propes stepped in often to check on me and encourage me that this phase would be over soon. Troy and Robin Smith listened to my fears and complaints over countless pancakes and baskets of tortilla chips. Amy Foster became a close friend and refuge during long writing days. I believe I spent as much time in her office as I did my own. Kent Dollar became a mentor to me in Tennessee when I had moved away from everyone I knew, and I could not have asked for a better one. His wit and compassion have made him the perfect department chair, traits he no doubt inherited from his kind predecessor, Jeff Roberts. Not everyone can say they owe their career to their aunt, but I can. Susan Laningham convinced me that this profession is the best in the world, and I thank her for that as well as sharing Tech with me. I also thank the students, who I did all this for. The History Club made me fall in love with the subject again when I had forgotten its purpose. Each of you mattered tremendously to me.

Last of all but first in all other ways is my husband, Allen Driggers. One thing I have learned about marriage is that some spouses are hurdles and others are springboards, and Allen is a springboard. If I had to thank only one person for talking me through this, it would be him. I firmly believe that every pot has a lid, and I don't know which of us is which, but we definitely

fit. He reminded me every day that the sun would rise and I could try again tomorrow. Hope is not easy to come by in the gutter, but he filled our little blue house with it. Thank you for loving our dogs, our life, and for loving me when I have not been loveable. I dedicate this work to you.

To end again with Wilde, I also appreciate the line because it can serve as a metaphor for long academic study. It embodies the idea that lofty goals and ideas should be honored for their own sake, even if not all the world can see their practical use. How many historians have been asked to explain their studies only to be met with blank stares? The reason, perhaps, is that we are looking at the stars. I firmly believe that history can make the world better by creating a world that knows better. What a grand belief for so many of us to hang onto, and I promise not to let go of it.

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I. Introduction

This study examines how medical education developed in the Southern states in the nineteenth century by comparing the foundation and challenges faced by three medical schools in Kentucky, South Carolina, and Arkansas. Many of the challenges faced by these medical schools centered around the conflicts inherent between people affiliated with the school and those outside it. At a moment in history when people were starting to reexamine their views on the authority of doctors and professionalization generally, this study seeks to understand how successful doctors and medical schools were at improving community trust. What did local physicians think of new medical schools? How did the status of schools as for-profit institutions—which all were before the twentieth century—affect what they did for the community? What kinds of community services did the schools offer, and how did race affect the validity of medical authority? How did public calls to improve and regulate the schools affect their reputations? While most of the scholarship on these issues has come in the form of institutional or personal biographies, a focus on the issues faced by these schools and their attempts to solve them allows for new perspectives on professionalization, education, and race during the foundation of modern medical education.

In 1910, Abraham Flexner, who was a Southerner himself, set out to investigate these problems plaguing medical schools. He published his findings in what is now referred to as the Flexner Report, and it forced many medical schools, especially in the South, to either change or dissolve. Ultimately, the publication of this report led to state funding for the medical schools discussed in this study and a renewed commitment of their communities to support them. On the one hand, the report played favorites, and it encouraged many schools that catered to African Americans and women to close. On the other hand, the attention garnered by the report saved

the original medical schools in Kentucky, South Carolina, and Arkansas even as it embarrassed them by casting light on their lack of sufficient libraries, buildings, and teaching hospitals.

The second chapter of this study will briefly trace the path of medical education in the United States as well as give a history of the literature and context of Southern medical schools and professionalization. This chapter will also introduce the three medical schools discussed in this study—schools in Kentucky, South Carolina, and Arkansas. The third chapter will chronicle the founding and rise of these schools. Many of these schools closed, merged, and evolved in the early years based on funding, regulation, student demand, and community needs. Beginning with these institutional histories will help the reader make sense of the case studies in subsequent chapters. The histories of these schools will also introduce the various problems that medical universities throughout the South faced and their early attempts to resolve them. The chapter ends with a brief look at the popular idea that only Southern doctors could train Southern students and explain the targeted market that many Southern medical students constructed in order to retain students.

The fourth chapter will focus on case studies of professional and interpersonal problems that occurred in the three states. The first case study covers the involvement of Charles Caldwell, a professor at Transylvania, who sowed discord and polarized the faculty at each Kentucky medical school where he taught. The second study follows the interpersonal rivalries that split the Medical College of South Carolina, including the problems caused by Thomas Cooper, who attempted to petition the South Carolina legislature to found a second medical school in the newly established capital of Columbia. The third study follows the University of Arkansas Medical School and the issues it faced when doctors with the Arkansas Medical Association turned against the school and started a propaganda war to ruin its reputation. The

last study examines the broader tensions between older faculty that taught largely through experience and younger faculty that relied clinical evidence and new scientific principles.

The fifth chapter examines the cultural fascination with dissection in the nineteenth century and the struggle that medical schools faced to secure cadavers. It begins by showing how schools' success depended on access to dissection material and trace their attempts to satisfy these needs without incurring community rage. Newspapers sensationalized dissection and created a community appetite for salacious stories about medical schools, especially in the South. In some cases, African Americans responded to medical schools and the stealing of black bodies with violence. This chapter also examines the links between medical schools and slavery, especially regarding the clinical practice of medical school faculty and students.

The sixth chapter offers a robust examination of the work of Abraham Flexner. The chapter includes a close reading and explanation of the Flexner Report, its consequences for medical schools in the South and the greater United States, and reaction to the report's criticism of funding for the schools, their lack of standards, and the lack of clinical experience they offered. The schools that survived the report tried to manage community interaction by advertising their usefulness and revamping their technology and services. In many cases, the local communities stepped forward to raise money and support the schools, and local newspapers promoted new hospitals built for the schools and advocated for changes in the law to allow for more dissection material.

Finally, the seventh chapter will summarize what happened to the medical schools and their communities in the decades after the period of reform. Over time, the faculty became better public representatives for the medical profession as they abandoned their public rivalries.

Despite this, many people, especially African Americans, remained wary of medical schools and doctors, and integration was a slow process that many medical schools resisted. The effect of the Flexner Report on race and gender in medicine will be examined in light of oral histories from black physicians' experiences.

II. Southern Medical Education in Context

On November 1, 1874, Dr. James H. Lenow secured the corpse of an African American man from the Arkansas state penitentiary, the place where Lenow had been the physician in charge for a couple of years since his graduation from medical school.¹ Because of his position of authority at the penitentiary, Lenow later wrote that he “could get any amount of dissecting material” from his workplace.² He wrapped the cadaver in a blanket and rode with it sitting beside him in his carriage to a shed at the Little Rock Barracks, where a surgeon friend at the military reservation had prepared a space for him. That evening, under the cover of the shed, Lenow began slowly and methodically dissecting the dead man. He did the bulk of the work most evenings, though he was helped by his friend, who had provided the venue. When it was all over, the entire dissection of the cadaver had taken over a month. This moment was significant for both Lenow and Little Rock because it marked the first legal dissection in Arkansas. The people of Little Rock and especially the State Medical Society thought the moment special enough to warrant commemoration, so in May of 1927, they erected a tombstone-like monument at the site to mark the event. Lenow had encouraged the recognition for his work. Writing an article the year before, he argued, “Many of the medical educational centers throughout the country have marked such spots with a slab or some appropriate memorial to identify it with its early medical history.”³ The monument, constructed because of Lenow’s

¹ W. David Baird, *Medical Education in Arkansas, 1879-1978* (Memphis: Memphis State University Press, 1979), 23.

² James H. Lenow, “Some Facts and the Difficulties that Confronted the Regular Physicians in this State in the Early Seventies and Which led to the Passage of the Law Legalizing Dissection, and Finally to the Establishment of the Arkansas Industrial University Medical Department,” *Journal of the Arkansas Medical Society* 22 (April 1926): 232.

³ *Ibid.*

work and self-promotion in his community, stands to this day. The episode likely strikes modern day readers as ghoulish. It is easy to imagine the smells, the cool night air, and the seclusion of the men—two living, one dead.

Despite the macabre nature of this anecdote, its deeper significance is in how it illustrates several aspects of the history of medical education and race in the United States. The story of the first legal dissection in Arkansas, much like the broader history of medicine, is a story of two communities. First, there were the medical communities affiliated with medical schools. These communities solidified their prestige through education, even if it was not always the traditional education people typically picture in well-lit universities full of books and exuding order. Medicine has been, throughout much of world history, self-taught, just as Lenow took it upon himself to explore the body in dissection. This is partly why the history of medicine does not have a clear and constant trajectory of progress—there are stops, starts, and steps backward. The publicity surrounding Lenow’s dissection would help him secure a spot on the faculty of the first medical school in Arkansas. Second, there were the communities of patients and practicing physicians. For this group, medicine and medical knowledge depended on a constant exploitation of those who had the least ability to fight against misuse of their bodies, just as the African American man whose body was intimately surveyed without his consent. Medicine operates within the boundary of communities, and the people who have sought care from doctors or hoped to become doctors themselves have viewed the medical profession differently. The way that Lenow would have understood medicine would have differed greatly from the perspective of the man he dissected.

Though medical schools had existed in an unofficial way in the United States since the late 1700s, there were relatively few of them until the nineteenth century, and most of those were

concentrated in the North. Medical education underwent a number of reforming impulses in the 1800s, as different sects of allopaths, homeopaths, and regular physicians vied for control of the medical profession at large by opposing the burgeoning number of schools. This unregulated growth of proprietary schools, reformers claimed, furthered the decline of graduation standards by competing with one another. Historians debate whether it was a mushrooming of schools that caused such poor graduation standards or surges of anti-elitism in Jacksonian America. State licensing boards and the American Medical Association, founded in 1847, consistently fought against those people who feared aristocratic professionalization of medicine. The Civil War had a detrimental effect on the progress of medical schools in the South, as many institutions that were set to open were delayed and existing institutions converted into hospitals. It was only after physicians gained a firmer understanding of bacteriology and philanthropic organizations of the Progressive Era took a greater interest in reviewing and funding medical schools that conditions had an opportunity to change. The South began toying with reform in the 1890s when the region established the Southern Medical College Association, but it was not until the Flexner Report that many for-profit schools were taken over by their states. These efforts at reform, at the start of the twentieth century, provide an appropriate epilogue to a study of the initial reception and obstacles of state medical schools.

Of the three states to be examined here, Kentucky was first, in the 1780s, to discuss the creation of a state medical school. After much political infighting, the school, named Transylvania University, was finally located in Lexington. The first students attended lectures in makeshift classrooms above a tavern, and the school's very existence was threatened by economic panics and a chronic lack of bodies for dissection throughout its first decades of operation. Transylvania's medical department closed in 1856, eclipsed by the Louisville

Medical Institute (renamed the Medical Department of the University of Louisville in 1846). Its students benefited from clinical instruction at Louisville Marine Hospital, but it also faced bitter competition from other schools in the Louisville area, to the detriment of its own standards and reputation. By 1900, Louisville had seven medical schools, but the standards of medical education in Kentucky remained stagnant until the Flexner Report, a tale almost identical to that of South Carolina and Arkansas.

South Carolina housed the first medical school in the lower South, the Medical College of South Carolina (MCSC). MCSC struggled with its proprietary status and was not controlled by the state until 1913. The founders of the Charleston school were almost all educated in Northern institutions, such as the University of Pennsylvania, the oldest medical school in America. MCSC flourished between 1824 and 1861 as it made money and attracted students, and the faculty maintained a prestigious reputation. However, the Civil War and an aging, clannish faculty killed its initial success. Troubled relationships with local hospitals and political battles between medical sects crippled MCSC. At one point, in the 1870s, the school even eliminated tuition fees in hopes of drawing support from the state. Yet progress remained slow, primarily because faculty members jealously defended their authority against anyone who differed with them, even when objectively true medical progress and new technologies challenged their beliefs.

Arkansas's journey in medical education began in 1879 with a proprietary school organized by a group of prominent physicians, most of them veterans of the Civil War, in the Little Rock area. The school struggled to receive funding from the start, and though it was initially named the Medical Department of the Arkansas Industrial University, it received little aid from the state. The school competed with two other proprietary schools, the Sulphur

Rock/Gate City Medical School and, more notably, the College of Physicians and Surgeons of Little Rock, until the institution that would become the current University of Arkansas Medical School (UAMS) teetered on the brink of closure. In 1911, the Arkansas General Assembly voted to take over the school, absorb it into the state education system, and bond it to the University of Arkansas in order to receive state funding. Despite this intervention, the school continued to struggle against political infighting and hostility from many physicians in Little Rock, who argued that it did not live up to the standards of their profession. This tumultuous relationship with the community would not change until after World War II.

Even though the histories of these medical schools sometimes differ, they also display recurring themes. Internally, their problems consisted of an unwillingness by faculty to work together or agree on core ideas about the medical profession. Externally, there was the constant concern of competing for student enrollment and prestige. Faculty members sought personal gain by resigning and starting their own schools or going to competitors. Educational standards suffered as investors looked for quick profits and students flocked to the schools that promised the cheapest tuition and the easiest degrees.

Practicing physicians complicated matters further, for their goals were incompatible with those of the schools. As one medical historian, John Ellis, has argued, “Physicians who depended exclusively on medical practice for a livelihood began to see clearly that their interests conflicted with those of the professors who derived a substantial portion of their incomes from student fees while producing new competitors in the medical marketplace.”⁴ Furthermore, local medical societies often refused to cooperate with the schools in other communities, where

⁴ John H. Ellis, *Medicine in Kentucky* (Lexington: University Press of Kentucky, 1977), 18.

separate societies already mistrusted and abused each other. When one society aligned with a school or included members of its faculty, the school was immediately in danger of condemnation by the other groups.

A principal cause of grief for early medical schools grew from the fact that medicine and science advanced at a cost many communities were unwilling to pay. The schools depended on clinical demonstrations that required human cadavers, but people were largely distrustful of anatomists and a barely professionalized medical sector that operated in mystery and secret. Anatomists held new and controversial beliefs about how the body worked and its place in religion that usually ran counter to public opinion.⁵ Fears of dissection were compounded by the understanding that medical schools needed bodies, and the most vulnerable sectors of the population—the poor and minorities—usually fell prey to medical school demands when grave robbers desecrated their graves. Riots, vandalism, and lurid media attention were not uncommon when a new medical school opened. Take, for example, the pistol shots fired through the windows of UAMS in the decade after its founding, and the fact that newspapers blamed a superstitious African American community. Layers of meaning lay behind that episode.

To remedy these problems, medical schools offered free or reduced services to the poor of their cities, although the quality of and motivation for offering these services is uncertain. In the case of Arkansas, one of the school founders opened a free clinic at the back of a local hardware store where “employees of the hardware firm were prone to annoy and poke fun at the patients and to warn them that they would most likely not come out alive. The patients were

⁵ Tiffany DeRewal, “The Resurrection and the Knife: Protestant Cadavers and the Rise of American Medicine,” *Literature and Medicine* 32 (Fall 2014): 391-392.

intimidated to such an extent that the clinic was almost deserted.”⁶ Even so, on the surface, these efforts reflected a desire to relieve tension between medical educators and poor citizens of the community. Furthermore, a preliminary exploration of some charity hospitals, such as one run by the Ladies Benevolent Association in Arkansas, show that faculty made large financial donations to the hospitals where their students trained in an effort to foster good relations.

My attempt to understand the problems faced by these early medical schools, and whether those problems were eventually overcome, begins by examining the founding of schools in Lexington, Charleston, and Little Rock through the nineteenth century, determining who provided the money for their operation and discussing how the schools operated. I also look at the records of medical societies in these towns to determine if their members supported or opposed founding of the schools. The quick rise and sudden collapse of many medical schools during this time testifies to the many obstacles they faced in an environment of lax regulation and stiff competition. Because a school’s success was closely linked to its ability to provide quality medical education through clinical instruction, I also examine the student experience in these schools. Efforts by schools to improve their image led them to offer services to locals and work with charities. These efforts may have kept the schools from closing, but it was government intervention as a result of the Flexner Report that ensured greater stability long-term. Flexner’s investigation into the quality of medical schools started, in part, because of complaints that the schools were unregulated diploma mills hungry for tuition dollars. Those complaints often originated in communities dissatisfied with services or treatments.

Though interest in the history of science and medicine has grown in the recent decades, profound holes in the research remain. The most noticeable one is the lack of scholarship on

⁶ Bulletin of the University of Arkansas, Medical Department, V (October 1916).

medicine and medical education in the U.S. South, particularly when compared to the wealth of research on medical developments in the northern United States and Europe. There are many reasons for this situation, including the scarcity of surviving records for the South and a persistent assumption that interest in the professionalization of medicine in the South has taken a back seat to the study of Southern agriculture. Yet Southern medicine and especially medical education were not absent from the overarching history of medical progress in the western world. The seeds of medical inquiry scattered and took root in surprising places, not least in Kentucky, South Carolina, and Arkansas.

Another gap in the existing research relates to how medical schools in the South were viewed by the public and other practitioners. Looking at local reception reveals a human story usually overshadowed by histories that focus solely on inventions and theoretical advances. Historical inquiries into professionalism and education in the nineteenth century should offer more than simple analyses of increasingly tighter regulations. For example, in *CSI: Dixie*, an interactive database of coroners' inquests from nineteenth-century Southern towns, historian Stephen Berry has concluded that coroners functioned as authoritative community peacemakers by reaching satisfactory rulings on deaths that reflected complex interactions of race, class, and gender.⁷ Such studies inspire reflection on the relationship between people affiliated with medical schools and the people outside them, an area of research full of possibility. When so much of a medical school's success currently depends on its relationship and usefulness to its community and state, asking how the proliferation of Southern medical schools founded in the nineteenth century sought to control their public image addresses both of these holes in medical history scholarship.

⁷ Stephen Berry, "CSI Dixie," <https://csidixie.org/>

The studies closest to investigating this aspect of medical schools are their own institutional histories, or biographies. These are often published by physicians or administrative officials at the schools who want to commemorate their school's founding or some other event in its history. Such narratives, which generally trace a school's development from its origins almost to the moment of publication face just skepticism about their ability to appreciate fully the interplay of past and present, but they are important for gathering basic facts about who founded the schools, what obstacles they faced, student recruitment and retention, and sometimes, what students studied.

A superior example of this type of history is the only book-length study specifically focused on medical education in Arkansas. Written by W. David Baird over forty years ago and commissioned by UAMS for its centennial, the scope of the work encompasses the years between 1819, when Arkansas became a territory, and 1978, the year before Baird published the book.⁸ Baird displays a thorough knowledge not only of medical education at UAMS, but also of the health and medical histories of the state that have closely affected the school. Baird's tale of UAMS is full of tribulation, as he focuses on the school's almost chronic struggle to adjust admission requirements in ways that would gain students while also retaining (or creating) a sound reputation, securing funding, and finding enough cadavers for hands-on study.

Baird's exploration of Arkansas highlights some of the consistent problems for medical schools throughout the South. Though he is more interested in chronicling the school's development than in analyzing it in light of other schools or the transformations in medical education and the medical profession, he lays an important groundwork for future historians interested in these topics. Baird argues that the quality of education provided by the early

⁸ Baird, *Medical Education in Arkansas*.

medical school was tempered by its position as a for-profit institution, which raises interesting questions about the relationship between the state and education in general. Furthermore, the study is a testament to the fact that the politics of founding a medical school or passing licensing laws have much to do with ideas about class and egalitarianism. Such questions as the kind of physicians who set the standards and the rules for the profession, the kind of students to be accepted, and even whose bodies are to be dissected plunge us into realms of cultural, economic, and political history.

Less successful is Kenneth M. Lynch's brief institutional biography of the Medical College of South Carolina, published for its tricentennial celebration in 1970 with the backing of the college's alumni association. Lynch, the first full-time faculty member of the college in 1913, and subsequently a dean and its president, emphasized the importance of a research center for the university, but his principle goal in *Medical Schooling in South Carolina* was to make known the state's medical past. Though Baird was a historian, Lynch and many others who produce these biographies have been physicians first and foremost, and their reasons for writing are often to promote the reputation of local personalities. This is not to say, however, that institutional biographies are not valuable for understanding larger trends in the medical profession and medical education, including such issues as rivalries between local doctors and the teaching faculty, race relations, and the tendency for media wars to erupt when a school's success is evaluated.

As for Kentucky, John Ellis's *Medicine in Kentucky* is one of the few works devoting even a chapter to medical education in that state. As the title suggests, education is only a small aspect of the story Ellis is trying to tell, and he limits himself to a recitation of the basic facts of origin. Though Arkansas, South Carolina, and Kentucky evolved differently, their institutional

histories all share common points and narrative threads. Like Baird and Lynch, Ellis is more interested in telling the chronological story of Transylvania's emergence than in analyzing its broader significance, so his work is largely anecdotal. Though Ellis does not focus primarily on medical education as Baird and Lynch do, all three scholars use other parts of their books to look at the evolution of frontier medicine and the epidemics that shaped medical history in their respective states, either to hamper or heighten their school's renown.

One approach that historians looking at the evolution of medical education have taken recently is to analyze a pivotal moment in a larger story. Shauna Devine's *Learning from the Wounded: The Civil War and the Rise of Medical Science* articulates how important the war was to future medical developments. One reason Kentucky is relatable to Arkansas is its internal political divisions in the Civil War, and many of the founders of these medical schools came from both sides of the conflict. Devine's central argument is that scientific practices and careful anatomical study "failed to take root within the larger American medical community because most antebellum doctors were concerned with medical practice, not science."⁹ Devine maintains that medical education advanced after the Civil War because of an increased commitment to communication between physicians, as seen in the publication of tracts from the U.S. Surgeon General's Office and the establishment of such fonts of knowledge within the medical community as the Army Medical Museum and the National Medical Library. These factors, reinforced by the availability of corpses and amputation materials for dissection and increased fervor among states to pass legal dissection acts, set the medical profession on the path to modernization. The war allowed physicians to create "new ways to produce and record

⁹ Shauna Devine, *Learning from the Wounded: The Civil War and the Rise of American Medical Science* (Chapel Hill: University of North Carolina Press, 2014), 6.

knowledge about the causes, treatment, management, and prevention of disease.... In the process, Civil War physicians, especially Northern physicians, transformed American medical science.”¹⁰

Despite these advancements, Devine does not dispute that the quality of education, better health care, and the availability of care to all people in the South paled in comparison to opportunities and advancements in the North. She consistently acknowledges her Northern focus, arguing that “the Civil War as a stimulus to American scientific medicine is largely a Northern story, and thus the South is not considered in this present volume.”¹¹ Though Southerners were interested in furthering medical education, the Confederate Medical Department suffered a chronic lack of equipment and medicine, its needs being secondary to clothing, feeding, and doctoring an army that the South could not support in the long term. The North developed wide-scale research projects and communication while the South did not.

However, understanding medical education in the South means more than taking on institutional biographies or even focusing on a transformative moment, and some books look at the origin of medical education in the United States as a whole. One such work is Martin Kaufman’s *American Medical Education: The Formative Years, 1765-1910*, published in 1976. Kaufman bemoaned the lack of books on the broader subject of medical education and the proliferation of institutional biographies, most of which, he claimed, were “written as if that school was the only one, or the best one.”¹² Before his book, the only study that had looked at American medical education generally was William Frederick Norwood’s *Medical Education in*

¹⁰ Ibid., 2.

¹¹ Ibid., 9.

¹² Martin Kaufman, *American Medical Education: The Formative Years, 1765-1910* (Westport: Greenwood Press, 1976), ix.

the United States before the Civil War, published in 1944. Kaufman's work is based largely on secondary accounts of the medical profession, institutional biographies, and other medical developments in the states, but he also looked at printed primary sources that show contemporary opinions about the schools. He argues that his work is not so much a history of individual medical schools as it is a history of the historical movements that led to changes in how students, physicians, and communities viewed the schools and the medical profession. Though his work is only about 150 pages, Kaufman provided a deeper analysis of the origins of medical schools in the United States than any other medical historian to that point.

Developments in medical education were not limited to the United States, and Thomas Neville Bonner takes on a broader study of medical training in his 1995 *Becoming a Physician: Medical Education in Britain, France, Germany and the United States, 1750-1945*. By looking at these countries together, Bonner finds that a variety of factors, from the Enlightenment and Industrial Revolution to curriculum reforms and growing opportunities for educators to profit from higher education were the driving forces of change in medical education. He makes several intriguing points, including that modern medical education is more rooted in the 1700s than historians have realized and that the reason European schools produced more modern physicians was that they were quicker than English-speaking countries to adopt clinical education. Bonner is also interested in the often-unexamined experiences of medical students, including their daily lives and social backgrounds. Most importantly, he suggests that it was not that medical schools were weary of clinical instruction as the most effective means of education as much as it was that they struggled to decide whether such instruction was better administered through personal apprenticeships or in large hospitals with lectures. Furthermore, Bonner argues that institutional biographies that have emphasized the weakness of proprietary schools have mistakenly assumed

that European schools were always more advanced. Like Kaufman, he also highlights the importance of scientific developments in affecting and advancing medical education. “By 1910, in any case,” he argues, “few educators or practitioners in any country questioned the need for serious scientific study and laboratory experience as indispensable parts of a medical education.”¹³ This perspective and the scope of his work provide an excellent context for how medical education in both the United States and the South matured.

However, most important for understanding the evolution of Southern medical education is the work of Steven M. Stowe. Though most interested in describing bedside manner and attempts to resolve wider cultural conflicts, such as faith, race, and politics with science, about one third of Stowe’s 2004 *Doctoring the South: Southern Physicians and Everyday Medicine in the Mid-Nineteenth Century* is devoted to the training of Southern physicians. Steeped in the letters, medical record books, and diaries of Southern physicians, Stowe offers a more intimate portrait of their thinking than other historians by insisting that “medicine was *essentially* shaped by a doctor’s subjective grasp of the physical and moral identity of local places and people.”¹⁴ Southern culture and medical developments, therefore, were intrinsically fused, even as doctors’ allegiance to certain scientific principles and practices sometimes put them at odds with their communities. Though he argues that his is not a comparative work, looking at Southern medicine in light of that in the North, Stowe sees some distinctive cultural features in the South that affected physicians daily. First among these was the large number of African Americans as

¹³ Thomas Neville Bonner, *Becoming a Physician: Medical Education in Britain, France, Germany and the United States, 1750-1945* (Baltimore: Johns Hopkins University Press, 1995), 10.

¹⁴ Steven M. Stowe, *Doctoring the South: Southern Physicians and Everyday Medicine in the Mid-Nineteenth Century* (Chapel Hill: University of North Carolina Press, 2004), 2.

both patients and doctors and the legacy of slavery on racial order. Second was the conviction among Southern physicians that their region was different from the North because of climate and diet, both of which affected health. Race and gender are important in the work as critical aspects of why and how students chose to study medicine, reflecting larger trends in history writing to explore the marginalized actors of the past.

Stowe answers valuable questions about medical education, such as why students in the 1830s began to attend medical schools instead of pursuing apprenticeships, as had been the norm of the past. Going to school to pursue medicine forced many men to combat prevailing ideas of masculinity that often tied them to success in agriculture. The urban nature of medical schools is important because they isolated students from old community ties and indoctrinated them with the importance and authority of physicians. By choosing to go to a medical school and become a regular physician, a student was essentially saying that all other sects and physicians practicing without a degree were inferior. When they left school, physicians faced local, communal needs that frequently trumped their university commitments to values and standards in the broader scientific community.

Medical schools in the South struggled to understand and brand themselves after the 1830s. As Stowe argues, “A struggle over academic requirements, it also was a struggle over the question of physicians’ identity: were they to be harbingers of a cosmopolitan medical science or should they be content to be the repositories of familiar, local practice.”¹⁵ Like Bonner, Stowe is very interested in what students did in classrooms and hospitals. He traces the process of becoming a physician, from attending lectures to observing in clinics, to dissecting bodies and writing theses. The fact that every student experienced each of these steps (even if in varying

¹⁵ Ibid., 16.

degrees of scrupulousness) testifies to a growing continuity in beliefs and practices among Southern doctors. “Linking all of these together was an emphasis on the personal scale of medical learning and thus on the subjectivity of the individual practitioner,” Stowe suggests. “It was a subjectivity that infused the school’s ideal of an exclusive scientific knowledge with a moral, as well as an intellectual, authority. It was a subjectivity that featured the school’s fraternal bonds as the chief mark of professionalism.”¹⁶ While such historians as Kaufman and Devine see the Civil War as the defining moment of medical practice and education in the South, Stowe sees more continuity in what he calls a “country orthodoxy” centered on personal experience and loyalty to the South. Relationships between students and the physicians who taught them were intensely personal and produced loyalties to men and ideas that often trumped larger developments within the medical profession.

Though he is more interested in the formation of a Southern physician’s identity than in the reception and response to the schools themselves, Stowe also analyzes the cultural perceptions surrounding medicine and education more closely than any other scholar. He argues that competition between proprietary schools was less about greed and professional standards than it was about local contexts and the communities where the schools were located. Communities determined what was orthodox and what was not, which, in turn, affected a physician’s economic success and his acceptance by other local physicians. The medical community was extremely competitive, with every doctor challenging the prestige and financial security of the others.

As much as this work deals with medical education, it also touches on the subject of the professionalization of medicine when it seeks to examine if and how doctors gained community

¹⁶ *Ibid.*, 74.

trust. Many historians and social scientists have approached the question of how professionalization evolved, exploring modern medicine's control over healthcare in the United States and other Western countries. Prior to the Flexner Report the marketplace of medical care was very competitive, with university trained doctors not yet having gained control. However, aligning itself with new scientific medicine and the state, modern medicine became the preeminent provider of medical care. Historians are divided about the motivations for this power grab. Paul Starr in *The Social Transformation of American Medicine*, argues "The medical profession has had an especially persuasive claim to authority. Unlike the law and the clergy, it enjoys close bonds with modern science, and at least for most of the last century, scientific knowledge has held a privileged status in the hierarchy of belief."¹⁷ Even compared to science, Starr argues, medicine has a most special status. Patients must trust physicians if they hope to transcend the illness and health issues that plague people throughout their life. However, Starr concedes that because of this need for trust, the authority that states and patients have granted doctors gives them additional benefits. As he explains it, "The profession has been able to turn its authority into social privilege, economic power, and political influence."¹⁸ Doctors are now some of the highest paid professionals in United States society, and they dominate the medical market, giving doctors what Star calls "professional sovereignty."¹⁹

Other scholars investigating professionalization take a different view. For instance, John Harley Warner in his study of nineteenth century Parisian medicine, submits that American physicians were interested in "the ways Parisian clinicians created new models of medical

¹⁷ Paul Starr, *Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 4.

¹⁸ *Ibid.*, 5.

¹⁹ *Ibid.*

science by using the free access they were granted to the bodies of patients and the new tools they developed for investigating disease.”²⁰ Consequently, Warner argues the professionalization of medicine in the United States can be seen through its integration of French medicine into its practice. Scientific transmission, much like cultural transmission, is the key to understanding changing medicine to Warner: “The transferal of Parisian medicine to America was not an inevitable consequence of American physicians’ studies in Paris, but rather the expression of choices and purposeful actions that must be accounted for.”²¹ In addition to this cultural transformation, he also believes, much as Michael Foucault states in the *Birth of the Clinic* that the depersonalization of the patient in America was inherited from Europe.²²

Warner has also identified another important aspect of the professionalization of medicine in the United States in the regional nature of medical education.²³ Changes in medical education were fostered in the South by the idea that Southern medicine was exceptional. As Warner explains, “From the 1830s through the end of the antebellum period, Southern physicians argued with growing conviction that Southern medical practice was distinctive and that, therefore, Southern practitioners ought to be educated through Southern medical institutions.”²⁴

²⁰ John Harley Warner, *Against the Spirit of System: The French Impulse in Nineteenth Century American Medicine* (Princeton: Princeton University Press, 1998), 3.

²¹ *Ibid.*, 6.

²² Michael Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (New York: Vintage, Reprint 1994).

²³ Also see Warner, *The Therapeutic Perspective: Medical Practice, Knowledge, and Identity in America, 1820-1885* (Cambridge: Harvard University Press, 1986).

²⁴ Warner, “Southern Medical Reform: The Meaning of the Antebellum Argument for Southern Medical Education,” *Bulletin of the History of Medicine* 57 (1983): 364.

Grander changes in medicine also contribute to the question of how medicine professionalized. Charles Rosenberg in his 1977 essay, “The Therapeutic Revolution: Medicine, Meaning and Social Change in Nineteenth Century America,” proposed that medicine itself changed from the anecdotal medicine of the ancients to the empirical and targeted therapies. Rosenberg maintained that, “The revolution in practice which took place during the century, the conventional argument follows, reflected the gradual triumph of a critical spirit over ancient obscurantism.”²⁵ Consequently, therapeutic dominance allowed the physician more power in the marketplace.

Other historians such as Roy Porter, who have looked at medical history from the patient’s perspective, also examine the professionalism question in their sweeping narratives of medicine. Porter, in explaining how physicians have maintained their autonomy, rails against the “paradox of the history of medicine: the unresolved disequilibrium between, on the one hand, the remarkable capacities of an increasingly powerful science-based biomedical tradition and, on the other, the wider and unfulfilled health requirements of economically impoverished, colonially vanquished and politically mismanaged societies.”²⁶ This negative interpretation of the transformation and professionalization of medicine also informs the work of Michael Foucault and Carl Elliot.²⁷

²⁵ Charles Rosenberg, “The Therapeutic Revolution: Medicine, Meaning and Social Change in Nineteenth Century America,” *Perspectives in Biology and Medicine* 20 (1977): 486. See also Rosenberg, *The Cholera Years: The United States in 1832, 1849, and 1866* (Chicago: University of Chicago Press, 1962).

²⁶ Roy Porter, *To the Greatest Benefit of Mankind: A Medical History of Humanity* (New York: W. W. Norton, 1997; Reprint 1999), 12.

²⁷ Foucault, *The Birth of the Clinic* and Carl Elliot, *White Coat, Black Hat: Adventures on the Dark Side of Medicine* (Boston: Beacon Press, 2010).

Finally, there are many gendered and racial aspects to the professionalization of American medicine. For instance, Thomas J. Ward in *Black Physicians in the Jim Crow South* explored the difficulties of the professionalization and the African American experience.²⁸ Mary Roth Walsh did the same for women in *Doctors Wanted: No Women Need Apply. Sexual Barriers in the Medical Profession*.²⁹ Such complex themes will be explored more fully in the conclusion of this dissertation.

Not just professionalization but also medical education as a whole cannot be satisfactorily studied without looking at its relationship to race, especially as it pertains to medical schools' use of cadavers. Stephen Kenny describes how the advancement of medicine before the Civil War depended on white doctors experimenting on and dissecting black bodies. They conducted more autopsies on slaves than whites, and most of the specimens collected for study in medical colleges belonged to African Americans. Kenny also argues that dissection itself, as well as the transportation and collecting of slave bodies, "not only reproduced but also intensified the social inequalities embedded in Southern society and contributed to the racialization and commodification of black bodies under American slavery."³⁰ Some historians, such as Harriet Washington in *Medical Apartheid* have more generally argued that whites profited from black bodies, while others, including Rana Hogarth in *Medicalizing Blackness*, look at more specific

²⁸ Thomas J. Ward Jr., *Black Physicians in the Jim Crow South* (Little Rock: University of Arkansas Press, 2010).

²⁹ See Mary Roth Walsh, *Doctors Wanted: No Women Need Apply. Sexual Barriers in the Medical Profession, 1835-1975* (New Haven: Yale University Press, 1977) See also an excellent commentary (note 7) on page 153 in Ann Hibner Koblitz, *Science, Women and Revolution in Russia* (London: Routledge Press, 2000).

³⁰ Stephen C. Kenny, "The Development of Medical Museums in the Antebellum American South: Slave Bodies in Networks of Anatomical Exchange," *Bulletin of the History of Medicine* 87, no. 1 (2013): 35.

race-medical relations in case studies, as she does for South Carolina.³¹ Histories of dissection, such as Michael Sappol's *A Traffic of Dead Bodies*, have also discussed the prominence of grave-robbing in black grave yards and the use of black bodies as cadavers for dissection.³² The bodies not only of African Americans but also of poor whites were known to fall prey to nineteenth-century anatomists, and Elizabeth Hurren's investigations of the dissected socially marginalized in Europe testifies to the fact that wealth as well as race determined who would be casualties to progress in medical understanding. Her empirical research in tracing exactly how the University of Oxford obtained bodies implies that anatomy departments often failed to convince the poor to sell their loved ones' cadavers because bad publicity about how medical schools obtained marginalized bodies turned communities against the schools.³³ Collectively, these analyses demonstrate that stories of scientific and medical progress are inseparable in the South from the exploitation of black bodies.

Taken together, the studies discussed above reveal trends in the founding and early operation of Southern medical schools that hold significance not only for medical education, but also for the complex relationships between the state and the entrepreneur, the doctor and the patient, and most importantly, the school and its community. Though all these works look at

³¹ Harriet Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (New York: Anchor Books, 2008) and Rana Hogarth, *Medicalizing Blackness: Making Racial Difference in the Atlantic World, 1780-1840* (Chapel Hill: The University of North Carolina Press, 2017).

³² Michael Sappol, *A Traffic of Dead Bodies: Anatomy and Embodied Social Identity in Nineteenth-Century America* (Princeton: Princeton University Press, 2002).

³³ Andreas Gestrich, Elizabeth T. Hurren, and Steven King, eds., *Poverty and Sickness in Modern Europe: Narratives of the Sick Poor, 1780-1938* (New York: Continuum, 2012) and Elizabeth T. Hurren, "Whose Body is it Anyway? Trading the Dead Poor, Coroner's Disputes, and the Business of Anatomy at Oxford University, 1885-1929," *Bulletin of the History of Medicine* 82, no. 4 (2008): 775-818.

medical education in one sense or another, their methods vary, as does the extent to which they focus on the American South. They all emphasize common themes, such as the proliferation of proprietary schools, the Jacksonian rejection of medical aristocracy, the Civil War's effect on medical education, the efficacy of reforms on school admission and graduation requirements, and the ability of regular physicians to discredit opposing sects and claim authority. Most of these authors agree that medical education in the South took a different path than it did in the North, though they do not agree on the reasons why.

In looking at three schools in Kentucky, South Carolina, and Arkansas, I argue that Southern medical schools in the nineteenth century attempted to overcome bad reputations as unorganized, unprofessional institutions that butchered the marginalized and incurred the rancor of more respected local doctors. From their founding, these schools tried to manage this reputation within their communities much as they do now, primarily through singing their own praises, arguing that Southern doctors needed to be taught in Southern medical schools, and offering services they hoped would prove their usefulness. Giving medical care at free or reduced cost allowed students to have human material to learn from, but it also had the potential to make a school's reputation worse if it performed unsatisfactorily. Furthermore, in an era when most medical schools did not receive much or any financial support from states, acceptance or support of medical schools was often decided by their savviness in working with local charity organizations and hospitals that supplied them with both patients and cadavers.

Ultimately, doctors themselves, because of the proprietary nature of their schools, their public rivalries, and their competition for the raw flesh which science would be created upon, were their own biggest obstacle to community trust. Later attempts at regulation would reveal the many flaws that medical schools had, but reports on the schools would also become weapons

in the arsenals of medico-politicians whose success depended on the public shame of their competitors. Doctors were public relations officials for themselves, and their success at promoting their own images was paramount in ensuring the stability of their jobs. But doctors were also public relations officials for the medical profession as a whole, and they were much less successful in that endeavor because tearing down competitors ensured personal success but it hurt the integrity of the profession more broadly. Mistakes that happened in the early years of Southern medical schools harmed the relationship between the medical community and the communities outside the medical profession. This was especially true for the African American community as the legacy of that distrust over dissection and medical experimentation extends to today.

III. Overview of the Three Schools

This research began with a question: Why do people trust doctors? Today, most people trust doctors because they believe doctors know more than laymen about cures and remedies for ailments. Diplomas on office walls show that doctors have passed some gauntlet which resulted in their gaining respect from other members of their profession. The public can trust doctors that go to rigorous medical schools. The public can trust doctors because other doctors trust doctors. Yet in the 1800s, in a period of time before licenses and qualifying exams told people who to trust and when most of the population was still uncertain as to which types of practitioners offered the most consistently successful treatments, a doctor's best hope of gaining respect came in alliances. The story of the practice of medicine in the United States has been a story of intense competition, especially before the professionalization of medicine, and when there was safety in numbers. Banding together with other doctors meant developing a network of shared medical knowledge and passing that knowledge on to prospective practitioners, but even more importantly, starting medical schools lent medical credibility.

This chapter traces the founding of medical education in Kentucky, South Carolina, and Arkansas as doctors tried to establish respect and make money by promising transmission of their medical knowledge to future generations of doctors. As they did this, they faced a number of obstacles such as thwarted desires to regulate the medical profession, the necessity of attracting students to their schools, and the expectation that the schools should be useful to their communities. Their answer to these problems was to conquer the medical school marketplace by providing education on distinctive Southern approach to medicine, thereby safeguarding their usefulness to their communities and justifying the existence of the schools they created.

Many of the doctors who founded medical schools in the South were trained by one famed American physician—Benjamin Rush. From 1769 to 1813, Rush taught thousands of students at the University of Pennsylvania, the first medical school in the United States, and he was so influential that students founded Rush Medical College in his memory after his death. Historians have struggled to chronicle all he did, but students who attended his lectures took away a central message: In order to be successful as a doctor, you had to earn the trust of your community. Rush talked regularly about how physicians should deal with patients. He began each course by explaining that patients had responsibilities to physicians. Patients, among other things, should choose a doctor who had received a “regular education,” “put such confidence in [the physician] as to follow his prescriptions,” “be faithful in disclosing the causes of diseases,” “never take medicine without the advice of the physician,” and “speak well of his physician.” However, and more importantly, Rush followed this prescription by emphasizing the physician’s obligation to those seeking treatment. Physicians should “show respect and good breeding” and treat women delicately and modestly, but as to diagnosing and treating patients, he believed it vital that physicians “let the patient relate the cause of [the illness] himself,” “let the family tell what they think it is,” and try to recommend “what remedies are used in the family.” Essentially, physicians had a responsibility to listen to patients. What Rush espoused was essentially a contract—a way to think about the success of the patient/physician relationship and the outcome of treatment as dependent on both parties to fulfill their roles.¹

Of course, many people throughout the nineteenth century tried to avoid doctors all together, and later chapters of this work will explain why. This choice was encouraged by the

¹ Daniel J. Swinney, “Notes on Benjamin Rush Lectures,” 1808-1809, Mss. 2/0085-01, Wood Institute Library, College of Physicians, Philadelphia, Pennsylvania, pgs 1-17.

plethora of family cures as well as home remedy books and potions readily available for sale. One of the most popular home medical guidebooks was *Gunn's Domestic Medicine or Poor Man's Friend* published in 1830 but often revised by John C. Gunn, a man from Tennessee and later, Louisville, Kentucky. The whole premise of Gunn's book was that medical professionals, who profited by doing what normal people could do just as well with simple common sense, could not be trusted. People must therefore take their health into their own hands. "Professional pride and native cupidity, contrary to the true spirit of justice and Christianity," Gunn wrote, "have, in all ages and countries, from sentiments of self-interest and want of liberality, delighted in concealing the divine art of healing diseases, under complicated names, and difficult or unmeaning technical phrases."² The phrase "free from doctor's terms" even appeared in the titles of some subsequent editions of the book. Besides such home medical manuals, there were also newspaper advertisements and medicine shows that hawked magic potions promising unprecedented health benefits. As for the medicine shows, they generally disguised themselves as entertainments, with people who had gathered to watch the performances being told about the new cure-all drugs for sale. These kinds of sales became such a problem in Arkansas that medicine shows were outlawed in 1908. Five years earlier, even legitimate doctors had been forbidden to advertise their practices and services at the risk of losing their licenses.³ "The tendency of mankind to favor quackery is a necessary consequence of the difficulties which attend the treatment of the disease," said one doctor in an address to the Kentucky State Medical

² John C. Gunn, *Gunn's Domestic Medicine, or Poor Man's Friend, in the Hours of Affliction, Pain and Sickness* (Springfield: J. M. Gallagher, 1835), 14.

³ Ed F. McFaddin, "The Growth of Arkansas Law Regarding the Medical Profession" in *An Anthology of Arkansas Medicine*, eds. C. Robert Watson, Marion S. Craig, Horace N. Marvin (Fort Smith: Arkansas Medical Society, 1975), 17.

Society. “Where legitimate medicine fails the patient tortured, [the patient] is easily induced to throw himself into the arms of the charlatan who is ever ready to indulge himself in unbounded expectations.”⁴ Ultimately, many patients simply placed their faith in the doctor administering to them. In a description read before the South Carolina Medical Society of a doctor who was well-loved by his patients, it was said “his patients felt the most entire confidence in his ability to relieve their sufferings; and we all know how much this condition of the patient’s mind contributes in many cases to the success of the treatment.”⁵

Before the advent of medical schools in the United States, practicing physicians trained other doctors through apprenticeships. Students of medicine lived with the physician’s family and worked under him for as long as seven years. Upon completion of the apprenticeship, the new doctor received a letter from his former mentor to prove his acceptance by the medical community. W. Porter Mayo’s *Medicine in the Athens of the West* argues that, before licensing laws, medical society membership and a letter from a respected practicing physician were the hallmarks of the trade and a sign of trust to the general public.⁶ In some ways, this allowed for more careful regulation of new physicians than the early medical schools. If educated by a known doctor, former students could more easily gain the trust of the community. The flaws of this system were, of course, that a student was only as well-educated as the local physician who

⁴ *Transactions of the Kentucky State Medical Society* (Cincinnati: Robert Clarke, 1870), 37.

⁵ *A Memoir of Dr. John Edwards Holbrook, Read Before the Medical Society of South Carolina, in Accordance with the Resolutions Passed at a Special Meeting, Commemorative of the Death of this Distinguished Member* (Charleston: Walker, Evans, & Cogswell, 1871), 5

⁶ W. Porter Mayo, and Walker P. Mayo, *Medicine in the Athens of the West, 1799-1950: The History and Influence of the Lexington-Fayette County Medical Society* (Lexington: McClanahan Publishing House, 1999), 37-38.

mentored him. Charles Caldwell, who would go on to teach at a medical school in Kentucky, complained that while the doctor he apprenticed under was congenial, he had no medical library and very little training himself.⁷

The founding of a medical school by doctors could win them respect from people outside the medical profession. In turn, a degree from a respected or widely recognized medical school carried some weight. Historian Kenneth M. Lynch notes the connection between attempting to found a school and attempting to gain fame, saying. “The self-promoting interest of doctors eager for prestige gave rise to many unworthy schools.”⁸ The schools discussed in this study were founded by doctors who, while doing something for their community, also had much to gain from their labors. It is important to remember that while this examines some of the institutional background of these schools, the patterns that emerged in their foundings and efforts to survive are much more the focus. In order to achieve success, medical schools had to be well-run businesses, selling their stamp of approval; and, like all businesses, attracting a steady supply of customers. In this case, that meant students. A school’s name recognition grew as the students increased, although that did not necessarily mean their reputation grew at the same rate. If the students a school produced did not prove capable as practicing physicians, it could reflect badly on the school and the physicians who organized it. The ultimate judges and juries of doctors, therefore, continued to be the patients who came into theirs and their pupils’ care, the students who paid for their education, and other physicians in the community.

⁷ Charles Caldwell, *Autobiography of Charles Caldwell* (Philadelphia: Lippincott, Grambo, 1855), 77.

⁸ Kenneth Merrill Lynch, *Medical Schooling in South Carolina, 1823-1969* (Columbia: Bryan, 1970), 9.

The founding of a formal medical school in Kentucky followed a different path than it would in South Carolina or Arkansas. The first medical school in Kentucky began as an appendage to an existing university, Transylvania University. This became the custom in starting Southern medical departments, as opposed to creating fully separate universities, as this had been the practice in the North. Attaching itself to an already successful college increased the likelihood of survival, even if the college did not provide direct financial support. Transylvania began as a seminary in 1780 when the area surrounding it was part of Virginia, but by 1799, as the land was absorbed into Kentucky, Transylvania University was formed. Because of the changes in this region during its early history, there is less information on Transylvania's medical beginnings than for later schools. Also, because the medical school was an add-on to an existing university, it preceded the records of more formal medical societies in the state. A local newspaper mentioned a group of physicians meeting weekly in Lexington, but little remains of the minutes and records.⁹

The first two medical faculty to give partial lecture courses at Transylvania were Dr. Samuel Brown who taught Chemistry, Anatomy, and Surgery and Dr. Francis Ridgeley who focused on Materia Medica, Midwifery, and Practice of Physic. Medical education at the time was piecemeal, and students hoping to practice medicine would attend lectures where they could while sometimes apprenticing under practicing physicians. Brown received most of his medical training at the University of Aberdeen in Edinburgh, Scotland, though he had also studied under Benjamin Rush in Philadelphia as did Ridgeley. As Rush received his degree from Edinburgh, he encouraged many of his students to study there as well. Though Transylvania had a medical

⁹ *The Kentucky Gazette*, January 23, 1800.

department by 1799, it was not until 1815 that it was restructured to resemble a medical school. In 1818, the school graduated its first doctor, and some students of Brown and Ridgeley would go on to become influential professors at the school.¹⁰ None of those students would be more responsible for the growth of the school than Dr. Benjamin Dudley, who had apprenticed under Ridgeley. Dudley, like many students in those early days, bounced back and forth between schools, attending lectures at Transylvania, the University of Pennsylvania, and abroad in France to complete their educations, but at Transylvania he met other students who would become professors there, including Drs. Daniel Drake and William Hall Richardson.

Transylvania University was proprietary and expected to operate on the tuition of its students. The Kentucky Legislature continuously rejected requests from Transylvania for state support, which would prove to be a common theme among medical schools in the South. Brown discussed such frustrations in letters to family members, who shared his belief that this was unfair, especially since other colleges in Kentucky received charters and financial support.¹¹ Initially, the faculty lectured students from their homes and charged ten dollars per course for lecture tickets. Anatomy lectures were the best sellers.¹² Despite these issues, Transylvania had a considerable amount of early public support from outside the medical community, including numerous endowments and \$28,000 for books from the local community, which was remarkable

¹⁰ Lewis Rogers, *Facts and Reminiscences of the medical History of Kentucky: An Address Before the Kentucky State Medical Society* (Louisville: John P. Morton, 1873), 5-6.

¹¹ Mason Brown to Samuel Brown, 7 March 1819, Catalogue Number 2015.02.0039, J. Brown's Liberty Hall Historic Site, Frankfort, Kentucky.

¹² Francis M. Massie and B. Eiseman, "History of the Transylvania Medical School: The Heritage of Medical Education in Lexington, Kentucky," *The American Surgeon* 31 (1965): 298.

for the time.¹³ Because of such gifts, the faculty of the medical school did not have to accrue massive debts for construction and medical apparatus.¹⁴ Even from its earliest days, and before the medical department was producing students, the board of trustees of Transylvania gave Brown and Ridgeley five hundred dollars to furnish the department's library and granted the professors salaried positions, a practice almost unheard of for medical schools of the time.¹⁵

By the mid-1800s, there was a growing belief that organization of doctors into societies and as faculty of medical schools produced better practitioners as it widened their exposure to different types of treatment. The formation of a medical school from this point on often began with a group of doctors who submitted a charter to establish the school. The result in South Carolina was the establishment of the Medical Society of South Carolina in Charleston in 1789. There were only eleven physicians in the organization at its founding, and though it was a state medical society, almost all of them hailed from Charleston.¹⁶ The society was created largely by Dr. David Ramsay, who, like many other physicians of the period, had been educated primarily by Benjamin Rush. Ramsay developed such a close relationship with Rush that he eulogized him and frequently reflected on the contributions Rush made to medicine. "To Dr. Rush every

¹³ William Allen Pusey, *Giants of Medicine in Pioneer Kentucky: A Study of Influences for Greatness* (New York: Forben Press, 1938), 37.

¹⁴ Hampden C. Lawson, "The Early Medical Schools of Kentucky," *Bulletin of the History of Medicine* 24 (1950): 168.

¹⁵ Robert and Johanna Peter, *The History of The Medical Department of Transylvania University* (Louisville: J. P. Morton, 1905), 6.

¹⁶ Joseph L. Waring, *A History of Medicine in South Carolina, 1670-1825* (Charleston: South Carolina Medical Association, 1964), 109.

place was a school,” Ramsay reflected, and “every one with whom he conversed was tutor.”¹⁷ Rush believed that democracy and education went hand in hand, and his commitment to teaching medicine inspired students like Ramsay to spread medical knowledge. Unfortunately for Ramsay, he never saw the culmination of his dreams for medical education as he was shot to death by an unstable patient in 1815.

The Medical Society of South Carolina had been discussing the prospect of starting a medical school for some time, but there had always been obstacles, especially financial ones. Medical schools of the period being so seldom funded by the state, people who bankrolled the schools entered into considerable financial risk by providing the building, books, and tools needed for instruction. Because there was no medical school in South Carolina at this point, most students had been attending Northern schools. The first proposal for a state medical school has long been believed to have come from Dr. Thomas Cooper, president of the South Carolina College. It is clear that Cooper hoped, being a part of the scientific community himself, that he could elevate Columbia specifically to a leadership position in establishing the South as the next frontier for medical advancement. In 1821, he gave a speech suggesting that the medical school be either entirely in Columbia or split between Columbia and Charleston.¹⁸ In fact, Cooper pointed to the success of Kentucky’s medical school as rational for a school farther South. “If the medical school of Kentucky has now ninety-three students,” asked Cooper, “is it too much to

¹⁷ David Ramsay, *An Eulogium Upon Benjamin Rush, M. D.: Professor of the Institutes and Practice of Medicine and of Clinical Practice in the University of Pennsylvania* (Philadelphia: Bradford and Inskeep, 1813), 99.

¹⁸ Dumas Malone, *The Public Life of Thomas Cooper* (New Haven: Yale University Press, 1926), 278.

calculate on one hundred and fifty for this place?”¹⁹ One of Cooper’s main arguments for the school was the amount of money it could generate for the state and how much the state could lose if more Southern states beat them to it.

In reality, Ramsay and other doctors from the medical society had been trying to establish a school long before Cooper sounded the call. Frustrated with the slow progress on creating a school, Ramsay started his plans to further education in South Carolina by convincing the Medical Society to host open lectures on Surgery, Physiology, and the Practice of Medicine. The society had also asked the Charleston College to create a medical school connected to that institution but the trustees of the college did not want to risk the financial burden.²⁰ After several failed attempts and not wanting Cooper and Columbia to steal the march on Charleston after Cooper’s speech, the Medical Society quickly sent a petition to the South Carolina legislature to establish the school there. It did make more sense for Charleston to be the choice for the school—Charleston had a greater population of potential students and it already had a hospital that could be used for teaching.²¹ For two years the Medical Society’s efforts were unsuccessful, but by 1823, the legislature had agreed that the physicians could set up a school as long as they did not expect funding from the state.

From the beginning the school and the medical society in Charleston were linked. In the act that created the medical school, it was specifically the Medical Society that had the right to

¹⁹ An Address Delivered Before the Medical Board of S. Carolina at Columbia, December, 1821 in IMG 9964 (9) in Columbia USC folder.

²⁰ Edwin McCrady, *An Historical Address, Delivered in Charleston, S. C., Before the Graduating Class of the Medical College of the State of South Carolina, 1885* (Charleston: Publisher Not Identified, 1896), 8.

²¹ Susan Dick Hoffius and E. Brooke Fox, *Medical University of South Carolina* (Charleston: Arcadia, 2011), 10.

choose the professors and the authority to dispense medical degrees, not the school itself. This set up the society as the de facto board of trustees over the college. As the society would later say, “The establishment of the Medical College was through the agency of the Medical Society alone,” and the society was “essentially incorporated as a medical college.”

It was not, however, the Medical Society’s main concern to pay for the school. As the society made clear, “The friends of the Society, it is too well known, are not in a condition to allow of extending any considerable pecuniary patronage to the proposed Seminary without exhibiting a degree of generosity inconsistent with prudence.” Instead, it was understood that professors would “take upon themselves willingly the burden of the expenses of the establishment.”²² This created a strange obligation on the members of the society who were elected to the faculty. South Carolina medical schools, as in Kentucky and later Arkansas, first emerged as a cross between a business and a charitable enterprise. Faculty hawked tickets to their classes, and when the students turned in the tickets, the faculty took them to the Medical Society, which redeemed them for payment to the professor.²³ Ticket sales were, therefore, the main source of income that professors had for their troubles. While many physicians wanted a medical school, there would always be conflict over whose responsibility it was to pay for it and, of course, control it. In the case of South Carolina, this tension between the faculty financially supporting the school and the Medical Society overseeing it would finally cause a break and the creation of two rival medical schools in Charleston to be discussed later.

²² Joshua Barker Whitridge, *An Exposition of the Affairs of the Medical Society of South Carolina, so Far as They Appertain to the Establishment of a Medical College in Charleston, and the Subsequent Division of the Latter, into Two Schools of Medicine* (Charleston: E. J. Van Brunt, 1833), 4.

²³ Hoffius and Fox, *Medical University of South Carolina*, 11.

It was not until five years after James Lenow's 1874 dissection that Arkansas finally managed to boast some semblance of a medical school. In Arkansas, the organizing of doctors faced contention among the ranks early on. While doctors had been forming groups in Arkansas as early as the 1840s, the Arkansas State Medical Association became the first state-wide organization founded in 1870. It lasted only a few years before being consumed with disagreements among its members and in 1875, the Arkansas Medical Society emerged as an alternative. Because it was founded after the American Medical Association, it required its members to be from Arkansas as well as to hold diplomas from AMA-acclaimed medical schools so they could remain in good standing with the AMA.²⁴ Philo Hooper was one of eight physicians from the Arkansas Medical Society who would work to create the first medical school in Arkansas, and initially, the medical society seemed supportive of the undertaking. Though Lenow would serve on the faculty, he was not among the founders of the school. As a student studying gunshot wounds in Thomas Jefferson Medical College in Philadelphia, Philo Hooper had an abiding interest in the human body and its treatments. Though he would become a practicing physician, Hooper believed, like many others, that the best way to improve medicine in the long-term was for physicians to share, through publication, experiences with other doctors. Hooper wanted to educate others, but when he returned to Little Rock, Arkansas, the community in which he had grown up and first showed interest in medicine, his opportunities to share knowledge were limited.

Initially, the founders of the medical school hoped to attach it to another institution already in place, much like the founders in South Carolina. They attempted an arrangement with

²⁴ "Arkansas Medical Society," Encyclopedia of Arkansas, <https://encyclopediaofarkansas.net/entries/arkansas-medical-society-7987/>.

St. John's College, but when that venture failed, Hooper and the others all pooled their money to purchase the Sperindio Hotel in 1879 with plans to run the school out of the building. While they used the charter of the Arkansas Industrial University (which later became the University of Arkansas), they did not have any access to state support. This meant the school would be known as the Medical Department of the Arkansas Industrial University. Once again, states and existing universities were happy to encourage the founding of medical schools as long as their dollars were not used to pay for them. So, with the financial burden resting solely on the faculty, each put forward \$625 of his own money to start the enterprise and expect that the school would be supported primarily by tuition dollars.²⁵ This meant that the founders were essentially stockholders in the school, and if there were enough students the professors stood a chance of making a sizable profit. As in South Carolina, the medical school was tied to the medical society in that faculty would be appointed "with the advice and consent" of the society.²⁶ By 1880, the medical department graduated its first and only student that year. As it happened, he had only completed his classes in Arkansas, having first attended lectures at the medical schools in Kentucky.²⁷

This issue of funding early Southern schools deserves close attention. While initial funding often came from faculty investment, their success largely depended on student enrollment and tuition dollars. It is hard to know exactly how many students passed through

²⁵ Max L. Baker, *Historical Perspectives: The College of Medicine at the Sesquicentennial* (Little Rock: College of Medicine, University of Arkansas for Medical Sciences, 1986), 3.

²⁶ "Extra," *Arkansas Medical Monthly* 1 (1880): 7. Viewed at the University of Arkansas for Medical Sciences, Historical Research Center, Little Rock, Arkansas. See Articles of Association & Charter, UA Medical Department 1879.

²⁷ Nolie Mumey, *University of Arkansas School of Medicine, with an Early History of the State, its Natural Resources, and the Founding of the University* (Denver: Range Press, 1975), 53.

Transylvania's medical department in the first years, but most historians agree that it was not until the mid-1810s that it boasted any semblance of an organized institution. Initially, classes were run out of the upper room over a local tavern. In 1815 there were anatomy and surgery classes being offered to twenty-five students, and by the next year, after the work of Benjamin Dudley to revamp the medical department's image, the class swelled to sixty. Again, Kentucky was different in its local financial support for the school. In 1821, the medical department at Transylvania purchased more teaching devices and a large medical library full of books from Europe to attract students, and while the state legislature kicked in \$5,000, it was the town of Lexington that contributed the remaining \$6,000 to help the school. The citizens themselves raised \$3,000 to guarantee the salaries of two of the professors.²⁸ Before it closed in 1856, the medical department at Transylvania had spent some years as one of if not the largest medical schools in the United States.²⁹ Only the University of Pennsylvania's medical department was bigger.³⁰ Clearly, even with the many obstacles the school faced, the founders and early faculty considered the business of starting medical colleges lucrative enough. Samuel Brown and Daniel Drake in their correspondence discussed the possibility of founding further medical schools in Cincinnati and Philadelphia, but only the Cincinnati project came to fruition.³¹

South Carolina's medical school began with thirty students in November of 1824 and had

²⁸ Niels Henry Sonne, *Liberal Kentucky, 1780-1828* (New York: Columbia University Press, 1939), 175.

²⁹ Pusey, *Giants of Medicine in Pioneer Kentucky*, 38-39.

³⁰ Charles Caldwell, *A Report Made to the Legislature of Kentucky on the Medical Department of Transylvania University* (Lexington: J. Clarke, 1836), 9.

³¹ Letters from February 14, 1819 and July 19, 1819, in Samuel Brown Papers 1817-1825, Mss. A B881, Special Collections, Filson Library, Louisville, Kentucky.

doubled that number by the next year.³² The first five students graduated in 1825 and every one of them had taken classes at some point elsewhere before they went to Charleston.³³ The school seemed to be flourishing and attracting more students in its early years, so much so that it required a new building, which the faculty again paid for. However, by 1831, the school was \$7,000 in debt and had to be bailed out by the state legislature, with no commitment to regularly support the school going forward.³⁴ The school won praise for its well-educated and publishing faculty, but that was not enough to make it a prosperous business venture. Soon, frustrations erupted between the faculty and the medical society over funding issues and control of the school that would tear the university apart.

Arkansas's medical school began with 22 students in the first year and increased to around 80 entering every year over the first eleven years in operation.³⁵ During that time, the number of faculty remained at around sixteen. That first year, the school earned a total of \$1,351 from student fees, even with tuition at only around \$63. Hopes were high that the school could earn considerably more with more students, and they were justified.³⁶ By 1887, the school was so successful that it had tripled the original investors' money.³⁷

³² Carolyn B. Matalene and Katherine E. Chaddock, *Vital Signs in Charleston: Voices Through the Centuries from the Medical University of South Carolina* (Charleston: History Press, 2009), 17.

³³ Hoffius and Fox, *Medical University of South Carolina*, 11.

³⁴ Joseph L. Waring, *Sesquicentennial 1824-1974: College of Medicine, Medical University of South Carolina* (Charleston: Medical University of South Carolina, 1974), 9.

³⁵ Baker, *Historical Perspectives*, 3.

³⁶ W. David Baird, *Medical Education in Arkansas, 1879-1978* (Memphis: Memphis State University Press, 1979), 36.

³⁷ *Ibid.*, 44.

Though much has been said about the financial risk of the founders of these schools, it must be noted how profitable having a connection to a medical school could be for a practicing physician. While they might not make much money initially from tuition fees, people likely perceived that a physician's medical skill was higher if he held a teaching position. Physicians who lectured made connections with their students as well as those who were likely to recommend cases to them or pay them for consultations in the future. As W. David Baird says in his book on medical education in Arkansas, "Many physicians were willing to work *gratis* or even to pay for the privilege of teaching at medical schools," which explains why the school in Arkansas had nine adjunct faculty appointments as early as the first year. These adjuncts taught without sharing in the profits of the school, but as Baird's research shows, these doctors became exponentially more successful in their in their private medical practices once they began teaching at the schools.³⁸

If the schools were to survive financially, they had to win the trust of their communities, a task that took many forms. One of the first steps to improving a community's trust in themselves and the medical profession was to eliminate practitioners who called themselves doctors but had no connection to other physicians in the area. Before the advent of medical schools, doctors had tried to regulate the kind of physicians allowed to practice medicine in their states but with little success. Membership in a medical society had sometimes been used by educated doctors to distinguish themselves from the ill-trained, but that was not enough to stop the latter from practicing.

When Charles Caldwell was arguing for the establishment of a permanent medical school

³⁸ *Ibid.*, 33.

in Lexington, Kentucky, one of his main points was that a local medical school would weed out unregulated physicians. He warned the community that western states were “becoming inundated with uneducated and unskillful pretenders to medicine,” and that only way to fix the problem was to educate “a sufficient number of...youth.” That would be the only way that a lay community could know for certain the reputation and accolades of its doctors. He talked about medicine in a language of dependency. The people of Kentucky should not be content to depend on doctors from other areas to minister to them. With your own medical school, “the youth of your own states would then become your physicians,” Caldwell argued. “In the existing state of things, you place yourselves too much in the power of strangers.”³⁹ Caldwell also saw that the community would better trust medical practitioners known to them. Having medical schools established in the region could thus build trust in the profession as a whole.

In South Carolina, Ramsay, like other doctors, was concerned with a lack of regular medical education among new physicians in the area. When the state legislature finally did pass an act to regulate physicians in 1817, the Medical Society of South Carolina begged the legislature for “censorial powers as a College of Physicians” to monitor new arrivals.⁴⁰ It was to no avail, but the legislature did outlaw the formal practice of medicine by any person without a license and created review boards in Charleston and Columbia to police the issue.⁴¹ This sparked further interest in the idea of founding a school because it meant a local place would be established where licenses could be obtained.

³⁹ Charles Caldwell, *Inaugural Address on the Advantages and Facilities of Establishing a Medical School in the Western States* (Lexington, KY: Thomas Smith, 1819), 13.

⁴⁰ Robert L. Brunhouse, “David Ramsay, 1749-1815: Selections from His Writings,” *Transactions of the American Philosophical Society* 55 (1965): 29.

⁴¹ McCrady, *An Historical Address*, 8.

In 1832, the territorial assembly in Arkansas recommended a panel to interview candidates who did not hold college diplomas or licenses from other states but hoped to practice medicine in the territory—Governor John Pope vetoed the bill because he believed that the licensure requirements represented government interference and an attempt by the more affluent and educated members of the community to rob the poor of an opportunity to practice medicine. Literally, the veto said that the attempt to regulate practicing physicians went “against the spirit of freedom.” Instead, citizens should be allowed to tolerate quack doctors if they wanted, while “the learned and qualified of the profession” were “at liberty to combat them.”⁴² When pleas for regulation continued to fall on deaf ears decades later, it was clear that lingering suspicion about doctors trying to profit by eliminating competition provided a primary motive for the anti-regulation sentiment. In 1877, the president of the Arkansas Medical Society angrily said of Arkansas lawmakers, “Those who are always looking out for the main chance, and standing always ready on the make for themselves, cannot award to others any higher motive.”⁴³ It was not until 1881 that a State Examining and Licensing Board was created, along with county branches established throughout the state. Henceforth, physicians had to pass a qualifying examination and pay a \$1.50 fee for the right to practice medicine, although some people continued to think even that too high a price to pay.⁴⁴

Trust also meant producing good physicians. It was apparent early on in the history of these schools that stricter admission and graduation standards would lead to a better quality of

⁴² Frank Vinsonhaler, *History of the Arkansas Medical Society* (Fort Smith: Arkansas Medical Society, 1943), 3.

⁴³ David M. Moyers, “From Quackery to Qualification: Arkansas Medical and Drug Legislation, 1881-1909,” *Arkansas Historical Quarterly* 35 (Spring 1976): 15.

⁴⁴ McFaddin, “The Growth of Arkansas Law Regarding the Medical Profession,” 17.

student and a more adept class of physician. As has been mentioned, since these early medical schools needed profits to remain open, there was always some fear of turning anyone away who wanted to pay tuition. This sometimes put medical societies in conflict with the schools. Many medical societies appeared to fear that poorly run schools degraded the reputation of the local medical community, and there were attempts by the societies to regulate schools any way possible. Arkansas's medical school prided itself on the fact that by the end of the century, only about one in four matriculants actually received their degrees.⁴⁵

Benjamin Rush told his students that practicing medicine was like a “three legged stool,” those three legs being “observation, experience, and theory.”⁴⁶ Medical education could also be seen as having three legs—“attention to books, hearing lectures, and attention to sick people.”⁴⁷ But the amount of education that students had upon entry into these medical schools varied tremendously. Many of the schools had no entry requirements except the paying of tuition, and some students had never even set foot in a school before they went off to become doctors at UAMS.⁴⁸

Lectures dominated much of the medical school experience for students, and they went from November to March at Transylvania, with each professor lecturing six times a week. The year's tuition was around \$110 by the 1830s, and two full sessions were required for graduation. After those two sessions, lectures were free to any students who wanted to continue to educate

⁴⁵ Baird, *Medical Education in Arkansas*, 44.

⁴⁶ Swinney, “Notes on Benjamin Rush Lectures,” 9.

⁴⁷ *Ibid.*, 12.

⁴⁸ Lillie B. Hill, *History of the University of Arkansas School of Medicine, 1879-1939* (Little Rock: University of Arkansas for Medical Sciences, 1939), 2.

themselves. Frederick Augustus Davisson went to Lexington, Kentucky, in the 1830s on his journey to becoming a physician. He took classes at Transylvania medical school from its most notable professors, Drs. Caldwell and Dudley, men whose publications and work in their communities initially gave Transylvania a decent reputation as far as medical schools went in this era. Davisson took good notes. He recorded the books that were suggested for him to read, books popular at the time, but his notes also reflect that medical knowledge in the 1800s was experimental, controversial, and personal as his writings reflect the differing opinions of his professors. “Dr. Dudley thinks his own plan better than any” for treating the retention of fluid in the genitals as it is “far more certain less painful and greatly more expeditious.” (Dudley used a knife to drain fluid as opposed to a needle, explaining the benefits of each to his students.)⁴⁹ Some students were less entertained by the lectures of their professors. Benjamin Evans complained that a Professor Short at Transylvania “commences his lectures in a reading like manner” and “there is nothing new or interesting about him.”⁵⁰ To ensure religious and moral instruction, Transylvania also had their students attend lectures by the local clergy, likely an opportunity to build trust and community outreach.⁵¹

South Carolina’s medical school had a similar lecture schedule of November through March, the reason being mainly that these were the months that cadavers—when available—lasted the longest for dissection. For the same reason, the school built a dissecting room separate

⁴⁹ Frederick Augustus Davisson, Notebook, 1830, OCLC Number 20737024, Rubenstein Library, Duke University Library, Durham, North Carolina.

⁵⁰ Benjamin Evans, *Such Bold and Fearless Eloquence: A Letter to Joseph Stanton Concerning the Transylvania Medical College, January 3, 1836*, ed. J. Hill Hamon (Frankfort: Whippoorwill Press, 1996), 5.

⁵¹ Caldwell, *A Report Made to the Legislature of Kentucky on the Medical Department of Transylvania University*, 6-7.

from the main school building to protect the lecture halls from the smell. In South Carolina, this schedule was also beneficial as it avoided the times of year when yellow fever was most prevalent. If students returned for a second year of instruction, they usually heard the same lectures repeated since, though most medical schools required two years of lectures, the second year was often only a refresher course.⁵² Lecture notes of students also show uniformity of instruction from year to year, with many similarities between the notes of different students studying under the same physician.

As in South Carolina, Arkansas's earliest medical school gave thought to where dissection would be most tolerable and so located its dissecting rooms on the third floor of the Sperindo Hotel while anatomical material was stored on the second.⁵³ The idea was that the smells of the cadavers would waft upwards and not bother the students and faculty in the lecture space below. After the Civil War, when the collecting of specimens for observation became more prevalent, students at UAMS at least had the experience of looking at Dr. Bentley's collection of preserved intestines, about which he had written and published profusely during his time as an army physician. At different points each of these medical schools opened anatomical museums to better educate students as well as thrill visitors with interesting finds.

Methods of examination also varied by school. Most medical schools held examinations as students neared graduation, but the medical school in Arkansas also held daily quizzes for students.⁵⁴ They also required that students be twenty-one years old by the time of graduation. In Charleston, the end of a student's time at medical school culminated with private

⁵² Matalene and Chaddock, *Vital Signs in Charleston*, 17.

⁵³ Baker, *Historical Perspectives*, 3.

⁵⁴ Baird, *Medical Education in Arkansas*, 41.

examinations by the faculty followed by an appearance before the Medical Society of Charleston where they defended their dissertations. The society then voted on whether the student should pass, and it was the president of the Medical Society that handed the student his diploma, not the university.⁵⁵ Transylvania's graduates merely appeared before an examination board of school faculty.

It is clear that these Southern medical schools initially functioned as a starter point for a student's medical education. If they showed promise then, much like their faculty mentors, the students headed somewhere more prestigious to supplement or finish their degrees. A 1939 history of UAMS said that "most of the graduates who attained distinction...completed their medical education elsewhere, taking postgraduate work at Tulane, John Hopkins, or some other better equipped institution."⁵⁶

Student experience in Southern medical schools varied considerably, but one common theme was the desire of professors and schools to cut costs when possible. As he began his lectures, Benjamin Rush made overarching comparisons to his educational experience between the United States and foreign medical schools by saying at the University of Edinburgh he had three professors, each teaching a different subject, while in America, the same professor taught as many topics as possible in order to lessen expenses.⁵⁷ Student complaints about medical school often hinged on frustration about lack of supplies or adequate facilities. In Arkansas, the hotel building that the school first utilized was cold and almost uninhabitable in the winter.⁵⁸ By

⁵⁵ McCrady, *An Historical Address*, 10-11.

⁵⁶ Hill, *History of the University of Arkansas School of Medicine*, 2.

⁵⁷ Swinney, "Notes on Benjamin Rush Lectures," 9.

⁵⁸ Baker, *Historical Perspectives*, 3.

1912, Arkansas students were sending their grievances to the Dean about a lack of proper equipment, which they said made it unsafe to treat patients:

On numerous occasions we have had members of our faculty to refuse to operate on account of the fact that such articles as rubber gloves, ligatures, drainage tubes and other operative equipment was lacking. In the name of humanity and for the good of the students we ask how a conscientious surgeon could be expected in this day of asepsis to endanger to lives of his patients and at the same time teach the students faculty technique. There is not one of you who do not realize the importance of thorough asepsis in surgery and especially in surgery which is done under conditions that are at best unfavorable.

Other complaints involved poorly lit and heated lecture halls and the university failing to provide an adequate number of hours of instruction, usually due to professors who simply failed to show up for lectures. The latter concern led to fears about how the AMA examining board would judge them. “We have failed to get 40% of the instruction which has been paid for,” they complained, and “the tuition and examinations have been well remembered while at the same time the students and instruction have been sadly neglected.”⁵⁹

Yet, gaining community trust ultimately depended on what they schools did in and for the community. Much of the argument that founders made for opening medical schools consisted of a pledge that local medical schools existed to serve their communities and would greatly improve the health of the people. The constitution of the Medical Society of South Carolina contained several sections on the responsibility of physicians to the public, one of which pledged, “As good

⁵⁹ “Grievances of the Senior Class,” 1912, 20DB4, Dean James H. Lenow’s Office File, Historical Research Center, University of Arkansas Medical School, Little Rock, Arkansas.

citizens, it is the duty of physicians to be ever vigilant for the welfare of the community, and to bear their part in sustaining its institutions and burdens.”⁶⁰ There was much local excitement when these schools opened their doors. Local newspapers published favorable evaluations, highlighting the importance of Southern medical education, the merits of the new faculties, and the usefulness of the institutions to citizens. Newspapers in Little Rock, Arkansas stated that the founding of its new school filled the state with “pleasure and pride.”⁶¹ Speeches given at the founding and opening sessions of the schools always implied that physicians had tremendous obligations to the communities they served. In his introductory lecture to the Medical College of South Carolina in 1837, Dr. Thomas Simons cautioned “I feel that my duty to this Institution, and to the community at large, demands of me to warn you against commencing the study of a profession so highly responsible as the one in which you are now about to be engaged.”⁶² He went on to add that “a scientific, virtuous, conscientious and sensible physician” must be “a benefactor to his race and generation.”⁶³

Some of the earliest attempts by physicians to aid and gain the trust of their communities centered on providing free healthcare to the poor. Even before schools were founded, medical societies attempted to staff clinics and dispensaries with local doctors. The Medical Society of South Carolina had begun planning for a dispensary in 1801, and it was one of if not the first such secular medical facility in the nation. Though the city of Charleston would contribute

⁶⁰ *Constitution and Code of Ethics of the South Carolina Medical Association as Revised 1887* (Charleston: Walker, Evans & Cogswell, 1889), 29.

⁶¹ “A First Medical College in Arkansas,” *Arkansas Gazette*, July 20, 1879.

⁶² Thomas Y. Simons, *Introductory Lecture Delivered at the Opening of the Session of the Medical College of S. Carolina, on the Second Monday in November, 1837* (Charleston: E. C. Councill, 1838), 7.

⁶³ *Ibid.*, 22.

\$1000 annually, physicians from the Medical Society rotated responsibilities amongst themselves to meet the majority of the dispensary's needs and care for its patients.

One of the most practical learning experiences students could have in nineteenth-century medical schools was to observe the faculty treating patients in their free clinics. This formed the “attention to sick people” aspect of training. When seeking to establish a permanent medical school at Transylvania, Charles Caldwell argued that there were three things a school needed in order to achieve success, or even survive: “a public hospital, an anatomical museum, and a public library.” He explained further, “A mere medical school, where only lectures are delivered, but which is destitute of certain requisite appendages, can scarcely flourish in a high degree. It resembles too much a soldier in the battle without his equipments.”⁶⁴

One of the biggest complaints about Transylvania's medical school time and again had to do with the small population of Lexington, which failed to offer an adequate number of patients to observe. A friend writing to Samuel Brown in 1819 lamented that Brown had chosen Lexington to teach, as opposed to a school with more sick people and “subjects for anatomy.” “To conclude,” he said, “you want stuff to work on; This you have not, nor can any human effort procure it.”⁶⁵ When Transylvania's medical department eventually faced stiff competition from the nearby Louisville Medical Institute (LMI), the latter wooed students with the promise of study in a working hospital which it had shared an affiliation with since 1837

Evidence from students offers insight to the benefits of such training. Courtney J. Clark

⁶⁴ Caldwell, *Inaugural Address*, 24.

⁶⁵ Letter from Dec 2, 1819, in Samuel Brown Papers 1817-1825, Mss. A B881, Special Collections, Filson Library, Louisville, Kentucky.

traveled from Alabama to take courses at the Louisville Medical Institute in the same era that Davisson went to Kentucky, and while Clark had similar lecture experiences with Kentucky physicians, his detailed notes show that he learned far more by observing patients at the Louisville Marine Hospital. He also saw how his work and the work of the LMI faculty also benefitted the poor of the community, who could receive low-cost medical care. The Louisville Marine Hospital saw nearly six-hundred patients a day, the majority of whom were immigrant sailors of German and Irish descent. Clark recorded the prescriptions and health plans of other physicians while closely monitoring the success of patients.⁶⁶ Another student, Will Anderson, wrote home about his experience at Louisville's medical school, saying, "I am assisting the doctors in the clinics four days each week and will continue for some time. I helped handle about forty patients in the surgical clinic this morning."⁶⁷ When most medical history books praise the progressive teaching methods of Northern schools, these notes show that the medical schools of the South made clear attempts to give experience while attempting to foster positive relationships with their communities.

The university medical school in Charleston required three years of apprenticeship from its students, which allowed them to serve the community while gaining much needed experience.⁶⁸ Students had the opportunity to observe patients nearby at the City Hospital, which

⁶⁶ Courtney J. Clark, Papers, 1841-1874, OCLC Number 20649131, Rubenstein Library, Duke University Library, Durham, North Carolina. For the composition of the Louisville Marine Hospital patients, see the folder on the Louisville City Marine Hospital, 1821-1867, Series 5, Hospitals in Kentucky in Kornhauser Health Sciences Library, History Collections & Archives, Louisville, Kentucky.

⁶⁷ Will Anderson Letter to Sister, February 25, 1891, W.W. Anderson Documents, SC 1304, Kentucky Historical Society, Frankfort, Kentucky.

⁶⁸ Waring, *A History of Medicine in South Carolina*, 109.

had more than sixty beds for patients, and the Marine Hospital for sailors, which housed almost as many. Once the school opened, it also established a free infirmary for the black population of Charleston, which, unlike the other hospitals, existed almost exclusively for the purpose of teaching. Although Charleston had a bustling population of over 40,000 people at the time, the richer, white citizens of the city did not generally use hospitals, but instead called doctors to their homes. Hospitals as a whole were used for the destitute and, before the Civil War, or slaves of the city. Plantations also frequently operated sick houses for their own slaves on the property, though the school's attempt to bring slaves to the city for treatment by the faculty will be examined in a later chapter. The city of Charleston even paid the medical school \$15,000 to sign a contract with the faculty to run the charitable hospitals of the city for the next twenty years.⁶⁹ Faculty reflecting on the success and usefulness of the medical school said, "The State gave nothing, until the School had obtained an elevated reputation, and had become useful in many points of view to the community-saving every year to the State the sums afterwards appropriated twice or thrice fold."⁷⁰ The relationship between the school and the city was not without some bitterness, however. When Charleston ultimately took control over the charitable hospitals, the faculty said that the city was "decidedly a gainer by the bargain made with it, and has profited in every way by our labours—which have been most ungratefully requited."⁷¹

In Arkansas, one of the faculty by the name of Edwin Bentley opened a clinic at the back of Fones Hardware Store next-door to the medical school, where he took students. He also made

⁶⁹ Waring, *Sesquicentennial 1824-1974*, 6-8.

⁷⁰ Grimke, "Statements," R 15.S6 S72, Addlestone Library, Charleston, South Carolina. See page 16.

⁷¹ *Ibid.*

use of the local hospital run by the Ladies' Benevolent Association of Little Rock. In 1891, a local doctor named Isaac Folsom donated twenty-thousand dollars upon his death for the medical school to open a clinic for students to treat the local community, although what became the Isaac Folsom Clinic did not open until 1911.⁷² The school itself required three years of courses, but students could opt out of the last year by securing an apprenticeship with a practicing physician. Students could also forego writing a thesis for graduation if they instead wrote a report on one of the clinics in which they worked.⁷³

There has been much scholarly debate about how much these free clinics benefitted or harmed the communities surrounding these schools. It must be noted that, while the doctors and many of their institutional biographies talked about the clinics as a service provided out of the goodness of their hearts, faculty and students also profited from their use. The treatment received by patients obviously varied tremendously, and so it is hard to say whether these institutions were entirely beneficial. That had much to do with the race and socioeconomic status of the patients seeking care which a later chapter of this study will address.

Providing public lectures was also a service to the community that medical societies provided, but unless they could promise morbid entertainment, the lecturers often spoke to mostly empty chairs. This was disappointing for physicians who saw themselves as being responsible for uplifting their fellow citizens, citizens who, as Dr. Benjamin B. Simons of the South Carolina Medical Society complained, "amuse themselves in taverns and places of much

⁷² Mumey, *University of Arkansas School of Medicine*, 62.

⁷³ Baird, *Medical Education in Arkansas*, 43.

less respectability.”⁷⁴

Doctors on the faculty of these schools realized that the biggest challenge they faced was to convince the public that Southern towns needed doctors who had been trained in the South by Southern doctors. This was training that only they, as Southerners, could provide. Charles Caldwell was a divisive member of the faculty at Transylvania University who understood the importance of Southern medical education. Originally from North Carolina, Caldwell had chosen to pursue medicine at the University of Pennsylvania, where, like many of the doctors discussed in this chapter, he studied under Benjamin Rush. In advocating for the establishment of medical schools outside of the North in 1819, Caldwell emphasized that different regions of the country had different medical needs. “Diseases are greatly modified in their character, by soil, climate, topographical influences, and the mode of life of the people they affect,” he pointed out. “In many parts of the world, different complaints, requiring different modes of treatment, are known to prevail on the opposite sides of a chain of mountains, and, in some places on the opposite side of a large river, or an arm of the sea.”⁷⁵

Accordingly, Caldwell offered a plan for improving the Transylvania’s reputation and getting the community’s support for the school based on the importance of teaching and practicing “Southern medicine” for both the health and advancement of Lexington. He argued that establishing more medical schools in rural areas would lift them “from wildness and destitution, towards maturity, opulence, and glory, ... [to define] a new and memorable epoch.”⁷⁶

⁷⁴ Waring, *A History of Medicine in South Carolina*, 136.

⁷⁵ Caldwell, *Inaugural Address*, 10.

⁷⁶ *Ibid.*, 5.

Thus progress and success were tied to medical education.⁷⁷ A medical school would provide the community with independence, bring it together, and allow it to prosper.⁷⁸

Almost seven decades later, in 1885, Edward McCrady made the same point in a speech before the graduating class of the Medical College of the State of South Carolina. He proudly recalled stories of the medical men who had served the state both before and after establishment of the college and marveled at the school's success. Very little was said about the fighting between the Medical Society and the professors, between the professors and students, and among the professors themselves. Instead, he focused on the need for financial support and the local pride in a medical school created in the South and run by Southern men. "Surely the State should encourage and assist an institution in which our young men can study medicine at home under the guidance of those who are familiar with our climate and its diseases," he insisted. Why should not South Carolina "encourage and assist a home institution, in which our students may fit themselves for the practice of medicine as it is affected by our climate?" Mentioning yellow fever specifically, he asked, "What are our young men to learn about that—save what the books can teach them—from physicians at the North, or in Europe, who have never seen a case?...Is it not well that those who are to minister in our homes should be of our own habits and manners, and should sympathize with us, as those of our own people, of our own education, only can?"⁷⁹

What McCrady was arguing was similar to what Caldwell had attested years earlier. Through the language of climate and a nineteenth-century understanding of disease, they

⁷⁷ Ibid., 6.

⁷⁸ Ibid., 7.

⁷⁹ McCrady, *An Historical Address*, 13.

believed that medicine which was to be administered to the community should be taught by the community. Thomas Cooper expressed similar sentiments when he said that a medical student from the South who studied in the North would “be apt to return home, a Northern practitioner.” Trained in the North, he would practice “under the influence of medical prejudice, engrafted from abroad.”⁸⁰ None of this addressed an even more pressing fact—Southern doctors wanted to keep medical school tuition dollars in the communities the physicians would ultimately serve. The story of the founding of these schools is a story of frustration that local government and often people outside of the medical profession in general could not see their importance. With such financial risk at stake for the medical societies and doctors who founded the schools, as well as pressure from students to meet their needs, medical schools struggled tremendously with these obstacles alone. Yet, even larger obstacles to success and the professionalization of Southern medicine in general were still to come, and they would come from within.

⁸⁰ Thomas Cooper, *An Address Delivered Before the Medical Board of S. Carolina at Columbia, December 1821* (Columbia: Gazette Office, 1821), 4.

IV. The Medical Community and its Rivalries

John C. Gunn's *Domestic Medicine, or Poor Man's Friend, in the Hours of Affliction, Pain and Sickness*, was a best seller of the nineteenth century and had multiple editions. Gunn, who was also a Southerner, commented in his medical guide about the problems inherent in medicine, but he focused on the rivalries between physicians as being the biggest issue. He commented, "A long practice in my profession has fully convinced me that more favorable results take place from simple remedies, and good nursing, than from eminent physicians who quarrel with each other for pre-eminence in fame, instead of endeavoring to enlighten and advance the happiness of the human family."¹ Testimonials like this, from inside the medical profession accurately summed up the state of professional medicine. Because medical education and medicine as a whole operated as businesses, there was a considerable stake in arguing that your school or you as a physician were superior to the competitors. Much of the competition inherent in medicine took place between physicians on the printed page, in their communities, and in the medical schools themselves.

This chapter addresses a question that the historiography of medicine has yet to fully examine: How did intrapersonal medical rivalries derail the legitimacy of medical schools, and perhaps Southern medicine? It examines the disputes between physicians, but it also probes attempts by medical schools to legitimize themselves, despite such intrapersonal arguments. In Kentucky, physicians wanted to have a prosperous medical school at Transylvania University but undermined their own efforts by personally attacking one another's reputations or starting

¹ John C. Gunn, *Gunn's New Domestic Physician, or, Home Book of Health: A Guide for Families, Pointing Out in Familiar Language, Free from Medical Terms, the Latest Approved Methods of Treating the Diseases of Men, Women, and Children, and for Using the Best New Remedies, Including Medicinal Plants* (Louisville: Printed for the author, 1857), 5-6.

competing medical schools. In South Carolina, the main fight centered on who controlled the medical school, especially in regards to appointing and removing faculty. The medical school faculty wanted power over who would join their ranks, but the local medical society argued that since it had created the school, it had the ultimate say. In Arkansas, the Medical Department at the Arkansas Industrial School received intermittent praise and criticism from the local medical society, but physicians ultimately rallied around the school to promote it to students and bolster the medical reputation of Arkansas as a whole. By examining these three states, historians can better understand the relationship between communities, physicians, medical schools, and the developing profession of medicine in the South. This chapter also complicates the narrative that physicians were always consciously working together for their collective good.

Scholars have examined the history of Southern education from a cultural perspective, especially focusing on the role of honor. Robert F. Pace's *Halls of Honor: College Men in the Old South* sees Southern education as necessary to the training of Southern men in public codes of Southern honor and character building.² Like Bertram Wyatt-Brown and others, Pace confirms that honor in the South was an important motivator in physical conflict, but extends the analysis to colleges and universities in the South.³ Similarly, Southern concepts of honor encouraged rivalries between doctors and contributed to a competitive rivalry culture in Southern medical education.

While a central mission of Kentucky's Transylvania Medical Department was to improve the reputation of medicine in the state, the faculty of the medical school attacked each other to

² Robert F. Pace, *Halls of Honor: College Men in the Old South* (Baton Rouge: Louisiana State University Press, 2011).

³ Bertram Wyatt-Brown, *Southern Honor: Ethics and Behavior in the Old South* (Oxford: Oxford University Press, 1982).

improve their own personal reputations. Disputes in Kentucky medicine are best exemplified by the medical career of Charles Caldwell, perhaps the most famous but also most controversial faculty member at Transylvania.⁴ Ultimately, his conflicts with professors at Transylvania would drive him to establish a new medical school in Louisville, Kentucky.⁵ Caldwell's problems were not unique to Transylvania, however, as he would go on to be banished from Louisville as well. Though Caldwell was a prolific contributor to medical publications, so too did he relentlessly castigate other members of the Kentucky medical community.

Because Caldwell was such a prolific writer, including penning an autobiography, historians have no doubt about the issues that mattered to him. He handed his autobiography over to an editor with the instructions to publish it upon his death, likely because the work was nothing if not expressive of his many views. Caldwell was arrogant and a self-promotor, even concerning the earliest parts of his life. When discussing his first year of formal schooling, he declared, “[I] became decidedly the best speller and reader in the institution; though several of my school-fellows were much older than I was, and had been two and three years under tuition.”⁶

Wherever Caldwell traveled, he made enemies. After his education at Princeton, he returned to his native Salisbury, North Carolina where he harangued his medical peers, but it was in medical education that he found and created the most conflict. Caldwell sought medical training at the University of Pennsylvania, where he eventually fell out of favor with Benjamin Rush, the most famous physician of the time. Though he had studied under Rush, Caldwell

⁴ Dorothy Long, “Caldwell, Charles” in *Dictionary of North Carolina Biography*, edited by William S. Powell (Chapel Hill: University of North Carolina Press, 1996). The online edition was also consulted: <https://www.ncpedia.org/biography/caldwell-charles>

⁵ Ibid.

⁶ Harriot W. Warner, ed., *Autobiography of Charles Caldwell* (Philadelphia: Lippincott, Grambo and Co., 1855), 65.

refused to defend and aggrandize Rush's signature theories in his medical thesis. It was such an embarrassment to Rush and the school that Caldwell was denied a professorship to succeed Rush. As always, Caldwell promoted his own ideas over those of his mentor. His own writings, he insisted, would "show me to have been one of the most original and independent thinkers of the day, and much the most copious medical writer in the United States, yet will they give me... less reputation than a single volume of five hundred octavo pages, even feebly composed, but more entirely suited to their tastes and wants."⁷ Caldwell was not sufficiently deferential to his more famous and respected predecessors, but he would not back down from criticism. In fact, it seemed that conflict only strengthened his convictions that he and only he was right.

Scandal and professional arguments followed Caldwell to Transylvania in 1819. He frequently and openly criticized the university and the medical school in particular despite his faculty position there. His autobiography noted that when Caldwell got to the school he had "thirty-seven pupils, but nothing that could be regarded as means for the instruction of them; no suitable lecture-room, no library, no chemical apparatus of any value, and no the shadow of a cabinet, or any description."⁸ Even though Caldwell became chair of the medical department, that did not stop him from criticizing it. There were only five professors, including himself, and but that did not deter him from openly criticizing their character. One professor, he declared, lacked "a proper kind of degree of mental cultivation and training."⁹

The rivalries in medical education in Kentucky worsened when Caldwell arrived, but there had been intrapersonal problems with the professors of the department before. James R.

⁷ Ibid., 239.

⁸ Ibid., 354.

⁹ Ibid.

Wright chronicled the feuds that resulted from a famous incident that occurred at Transylvania during 1817-1818.¹⁰ It all began when William Hall Richardson, William Dudley, and Daniel Drake, all professors at Transylvania's medical department, were called to perform an autopsy on an "intoxicated Irishman" who had injured his head, presumably leading to his death.¹¹ Drake did not want to attend the autopsy of the body because he had plans to travel to Ohio, where in fact, he wished to visit Cincinnati's medical department in anticipation of leaving his post in Kentucky. Yet, when Dudley's findings regarding the Irishman's death were published, Drake publicly criticized them, despite not witnessing the autopsy. Feeling insulted by the remarks, Dudley responded that Drake had "disregard both of the law and his professional duty."¹² Both men then attacked each other in print, with Drake impugning the character and morals of Dudley. William Richardson then entered the feud on the side of Drake, probably because Dudley had previously tried to have Richardson fired from the university. Neither man appears to have explained why he objected to the autopsy report, but Dudley, because not only his medical skills but also his honor had been called into question, challenged Drake to a pistol duel.

Ultimately, Drake backed down from the duel, explaining that he was against the barbaric practice. Richardson heroically took his place, only to have a major leg artery cut. He would have died had not Dudley, the man who shot him, been able to save his life.¹³ All three men appealed to the public, with the opposing sides claiming the other was destroying the medical

¹⁰ James R. Wright Jr., "Early History of Transylvania Medical College: The Sage of a Disputed Autopsy Precipitating a Duel and Grave Robbing," *Clinical Anatomy* 32 (2019): 489-500.

¹¹ *Ibid.*, 494.

¹² *Ibid.*

¹³ J. Hill Hamon, *Two Letters Concerning the Early History (1817-1818) of the Medical College of Transylvania University* (The Whippoorwill Press, 1993), 10.

school.¹⁴ Christopher Columbus Graham, a student who helped in the dissecting room at Transylvania and had assisted Drake in stealing corpses for his medical research, published an account of the duel that left no doubt of the growing animosity between the medical professors at Transylvania,¹⁵ as did a pair of scathing letters published after his death.¹⁶ As a side note, the community of Lexington took action to make dueling illegal.¹⁷

The duel caused such a tense atmosphere in the medical department that lectures were suspended for the following session. Drake was so mad about the duel and hated Dudley so much that did leave Transylvania's medical department for Cincinnati. Believing that most people thought he was trying to destroy the school while still working there, Drake wrote *An Appeal to the Justice of the Intelligent and Respectable People of Lexington* in 1818 to try to explain his side.¹⁸ Apologizing for what became a "private and personal dispute," he defended himself against charges that he had broken an oath to the school to work there longer.¹⁹ He had never promised to work at Transylvania for a specific amount of time, Drake insisted, and had not been "ungentlemanly," as people called him, in resigning. Drake had let everyone know he was planning to leave the school and had certainly never intended "to destroy the Medical

¹⁴ Wright Jr., "Early History," 495-498.

¹⁵ Ibid., 496, but see also North Carolina Encyclopedia article mentioned above regarding Caldwell.

¹⁶ Hamon, *Two Letters*

¹⁷ Wright Jr., "Early History," 497.

¹⁸ Daniel Drake, *An Appeal to the Justice of the Intelligent and Respectable People of Lexington* (Cincinnati: Locker, Reynolds & Co., 1818), University of Kentucky, Special Collections Research Center. See also Emmet Field Horine, *Daniel Drake (1785-1852): Pioneer Physician of the Midwest* (Philadelphia: University of Pennsylvania Press, 1961)

¹⁹ Ibid., 4.

College.”²⁰ Drake also published personal letters he had exchanged with his former faculty who were now on the attack. Much of the correspondence, even between alleged friends, was preachy, arrogant, and condescending.²¹

The incident exposed the vicious infighting between faculty at Transylvania, exposed deep interpersonal and professional rivalries, and showed that, in defending their personal reputations, faculty significantly hurt the dynamic, and perhaps the success, of the medical college. The conflict hit its apex when the always mercurial Charles Caldwell joined the fray. Noting the animosity between his friends and the faculty that supported Drake, Caldwell declared, “I feel it my duty to inform you that Dr. Drake and his colleagues are making a desperate effort to establish a medical School in Cincinnati, and have advertised a course of lectures for the coming winter.” Caldwell decried them as enemies and the future school as a competitor “however puny their efficiency may be.” Caldwell argued that the situation was more than a simple threat to Transylvania that everyone had to be on their guard (presumably to maintain the students that they had). “In fact the crisis requires that we be all at our posts. I propose to be at mine in a few days; and will not quit it again until the completion of the lectures in the spring.”²²

Division and slander had become such problems at Transylvania that in 1819, professor Samuel Brown endeavored to establish a fraternal society, Kappa Lambda, among the medical students that would encourage good feelings among the next generation of physicians. As Dr.

²⁰ *Ibid.*, 6.

²¹ See Samuel Brown Papers 1817-1825, Mss. A B881, Special Collections, Filson Library, Louisville, Kentucky.

²² Charles Caldwell Letter, August 30 1820 in Samuel Brown Papers 1817-1825, Mss. A B881, Special Collections, Filson Library, Louisville, Kentucky.

Frederick Ebersson states in his book on Kentucky medical leaders, Brown “visualized Kappa Lambda as an idealistic brotherhood for uniting its members against the discord and dissension then existing in the medical profession.” Clearly other physicians at the time shared his concerns, as Kappa Lambda spread to medical schools far and wide, including Philadelphia which had long been the seat of medical training for physicians in the United States. Members pledged to “promote the welfare of his colleagues in and out of the society, and to adhere implicitly to a strict code of ethics prepared for guiding the members in their relations with each other and with society at large.”²³ Despite Brown’s efforts, Kappa Lambda dissolved its chapters in 1836, leaving the continuing issue of professional harmony to be fully settled.

For students, any threat of a break or a fracture of a school could cause panic. In 1836, rumors began to circulate that Transylvania might move to Louisville because the city was bigger and appeared to have less strict laws about acquiring cadavers. Louisville also had the Marine Hospital for clinical instruction. The Trustees at Transylvania were very upset at the idea of a school being founded in Louisville and complained about it. As reported by the Legislature of Kentucky, “Great has been the surprise of the trustees at the movements in a neighboring city to dismember Transylvania, by removing her medical college from her own jurisdiction to the city of Louisville, and still greater is their surprise that this project of dismemberment has engaged the serious attention of the Legislature.”²⁴ The main issue early on was fear that a medical school established in Louisville in Transylvania’s name would take its charter. The

²³ Frederick Ebersson, *Portraits: Kentucky Pioneers in Community Health and Medicine* (Lexington: University of Kentucky Medical Center), 35.

²⁴ Quoted from *Journal of the Senate of the Commonwealth of Kentucky* (Frankfort, KY: Brown & Hodge, 1836), 100. See also Charles Caldwell, *A Report Made to the Legislature of Kentucky on the Medical Department of Transylvania University, February 15th, 1836* (Lexington, KY: J. Clarke, 1836).

trustees argued that some medical faculty only wanted to go to Louisville in order to monopolize medical training in the area. The trustees knew it would be a huge disruption to current students if the medical department were to move one hundred miles away, but it would also be a massive betrayal of the people of Lexington who had invested community money into Transylvania's building and library. Trustees begged the state to take over the school but to no avail.²⁵

By 1837, because of the clash of personalities, duels, and intrapersonal rivalries, paranoia among faculty started to pick up. A charge of conspiracy was brought to the trustees involving Caldwell and another professor, Lunsford Pitts Yandell, who were thought to be making plans to move Transylvania's medical department to Louisville themselves. Caldwell was ultimately fired, at least partly because of these accusations, which turned out to be true. Yandell, Caldwell, and another Transylvania Professor, John Eaten Cooke, did go on to create another medical school at Louisville called the Louisville Medical Institute. That worked for a while, until Caldwell was removed for his continued inability to get along with other faculty.

The Louisville Medical Institute was a largely successful institution, and by its third year had the third largest enrollment in the nation behind Pennsylvania and Transylvania. However, Louisville also acquired the same problem as Transylvania in regards to the faculty fighting each other, and in Louisville, the community caught on quickly. On May 19, 1837, the Lexington *Observer & Reporter* ran a story entitled, "Doctor Charles Caldwell, his hostility to the Transylvania Medical School."²⁶ The article demurred, "We had thought, nay, confidently

²⁵ Ibid, 100-103.

²⁶ Citation found and followed up from page 154 in Alma Wynelle Deese, *Kentucky's First Asylum: A Saga of the People and Practices* (Bloomington, Ind: iUniverse, Inc.,2005), see article of December 28, 1836 in Lexington *Observer and Reporter*, "Doctor Charles Caldwell, his hostility to the Transylvania Medical School."

hoped, that we should not again be called on for any further remarks on the subject of the late occurrences connected with the hostile movements of the person whose name heads this article.”²⁷ People in Kentucky could see that medical schools were having trouble with their own physicians, and if physicians did not trust each other, why should anyone else trust them?

In 1838, the *Transylvania Catalogue of Medical Graduates* clarified that, even though the school had fewer students than in previous years, it was doing just fine, which “proved, beyond controversy, that the school has too warm a place in the affections of its numerous alumni, to justify a doubt concerning its future welfare.”²⁸ The catalogue went on to say, “No material change occurred in the School, until the year 1837, when a disruption ensued, that seemed for a short season, to jeopardize its very existence. The Trustees, however, undismayed by the circumstances that had gathered around them, soon succeeded in effecting a reorganization.”²⁹ Enrollment only fell fifteen students below the previous semester and continued to be a cheaper option than Louisville.

The battles between the Transylvania medical department and the Louisville Medical Institute hurt the reputation of medicine and physicians in Kentucky. As the two schools continued to war with each other, physicians in Kentucky got involved. In 1841, they gathered to standardize medical education at the Lexington Medical Institute and Transylvania and to

²⁷ Ibid.

²⁸ *Transylvania Catalogue of Medical Graduates* (Lexington, Ky: Intelligencer Press, 1838), 4, Kornhauser Health Sciences Library, History Collections & Archives, Louisville, Kentucky.

²⁹ Ibid., 29.

agree on graduation standards, all to minimize damage to the reputation of medicine.³⁰ The convention was especially concerned that slanderous accusations against fellow doctors be avoided.³¹ Their mission, stated in the by-laws agreed to by the convention, prioritized working together for the benefit of the “profession.” More specifically, they vowed to refrain from personal attacks so that “harmonious intercourse in the profession may be promoted” and agreed to “regulations... directing practical action of our physicians into concert, uniformity, and efficiency—to the end that through these means all the talent, all the learning, all the energies, of the entire faculty of Kentucky, may be brought to bear on every point of difficulty, or interest in our science.”³² It was likely the phrase “the entire faculty of Kentucky” was meant to end the fighting between the two schools.

The convention recognized that rivalries between physicians hurt the profession as a whole. When disputes between doctors “end in appeals to the public, they most hurt the contending parties—but what is worse is they discredit the profession and expose the faculty itself to contempt and ridicule.” In disagreements which might “affect the honor and dignity of the profession,” the convention suggested that medical societies arbitrate them, but news of the dispute should not “be communicated to the public as they may be personally injurious to the individuals concerned and can hardly fail to hurt the general credit of the faculty.”³³ Debates between doctors were to be removed from the public arena and conducted within the profession.

³⁰ *Journal of the Proceedings of a Convention. of the Physicians of Kentucky.* Typed manuscript by R. Peters on 1/8/40, Transylvania University Special Collections, Lexington, Kentucky.

³¹ *Ibid.*, 6-10.

³² *Ibid.* 6-7.

³³ *Ibid.*, 9-10.

Kentucky doctors realized at least on the surface that the medical profession must retain the appearance of unity if it wanted community respect.

South Carolina would also face disputes among physicians associated with medical schools, but there, division hinged on the question of which group controlled the medical school and held medical authority over the state. The groups in contention were the local doctors of the state Medical Society against physicians on the faculty at Charleston's medical school. One of the most prominent physicians in South Carolina history, David Ramsay, spoke often about the problems in medical practice, especially the difficulty of getting the medical community to agree on important issues.³⁴ Regulation of the medical community in South Carolina had been much contested, and in his *History of South Carolina: From its First Settlement*, Ramsay lamented that previous efforts to solidify medical practitioners had been largely failures.³⁵ In a telling comparison, he pointed out that while clergy and lawyers had to be licensed and judged to have met minimum qualifications, "the practice of physic is free to every man or woman who chooses to undertake it."³⁶ However, Ramsay remained optimistic and eager to boast about the improvement of medicine in Charleston generally, and he stressed the importance of the Medical Society of South Carolina as a triumph.³⁷ He was also enthusiastic about the possible founding

³⁴ Arthur H. Shaffer, *To Be American: David Ramsay and the Making of the American Consciousness* (Columbia: University of South Carolina Press, 1991),

³⁵ David Ramsay, *The History of South-Carolina: From Its First Settlement in 1670*, Volume II (Charleston, SC: David Longworth, 1809), 114.

³⁶ *Ibid.*, 114.

³⁷ *Ibid.*, 105 and 120.

of a medical school in South Carolina, although, tragically, he died at the hands of one of his patients before that dream could be realized.³⁸

Ramsay had been interested in passing a code of ethics as a means of resolving disputes that degraded the profession. However, despite several attempts to pass such a code by the Medical Society, infighting among physicians—the very problem the code sought to address—killed the effort.³⁹ Nonetheless, the Medical Society was a uniquely powerful force in early South Carolina.⁴⁰ It functioned like many medical societies of the eighteenth and nineteenth century, with members presenting papers on medical cases and scientific interests.⁴¹ The society often advised the government, and it included not only physicians, but also a “Humane society” (which was a dispensary for the public), a “Botanic garden,” and a “medical police of Charlestown.”⁴² Members of the society aided the City Council with questions, helped to restore people who had fallen into the port waters, and helped educate young physicians.⁴³ As Ramsay noted, “The young physicians, when admitted members of the medical society, are classed into pairs; and in monthly rotation with the elder members, prescribed to attend on the dispensary patients.”⁴⁴ The result, he believed, was “a conspicuous opportunity for inducing their industry,

³⁸ See Joseph Ioor Waring, *A History of Medicine in South Carolina, 1670-1825* (Charleston, SC: South Carolina Medical Association, 1964) and Susan Dick Hoffius and E. Brooke Fox, *The Medical University of South Carolina* (Charleston, SC: Arcadia Press, 2011)

³⁹ Robert L. Brunhouse, “David Ramsay, 1749-1815 Selection of His Writings,” *Transactions of the American Philosophical Society* 55 (1965): 29.

⁴⁰ Ramsay, *The History of South-Carolina*, 105.

⁴¹ Thomas Neville Bonner, *Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750-1945* (Oxford: Oxford University Press, 1995), 77.

⁴² Ramsay, *The History of South-Carolina*, 106.

⁴³ *Ibid.*

⁴⁴ *Ibid.*, 107.

talents, and acquirements to public observation.”⁴⁵ Unfortunately, this educational mission would be the cause of animosity between the future school and society.

Though the Medical College of South Carolina was founded in 1824, it would split in 1832 because of divisions within the faculty about the nature of the society’s authority. The split came when a professor showed up to teach his class while drunk. The faculty decided to fire him, but this raised the question of who held the authority to replace him. Was it the prerogative of the faculty of the medical school or of the Medical Society? Ultimately, the dispute was not just about faculty appointments as the society seemed to hold the power to grant degrees. Controlling or at least remaining involved with the medical school became extremely important for the society as a means of being connected to the process of creating respectable physicians. However, when the Medical Society insisted its authority was paramount, the entire faculty of the school quit in protest and founded a new and competing institution.⁴⁶

The Medical Society retained possession of the original school’s buildings, so the new school had to rent its own facilities. This enraged the faculty, who publicly complained that they had “had to put the College in repair at their own expense; a new roof being required to save the building.”⁴⁷ Now they were out the money they had used to fix the old buildings and out the money they now had to pay for rent for the new school. One faculty member, James Moultrie, began spreading rumors that the old school building was ruined and the college would not survive.

⁴⁵ Ibid., 107.

⁴⁶ Thomas Y. Simons, *Introductory Lecture* (Charleston, SC: E. C. Coumcell, 1838), 23.

⁴⁷ Ibid.

Unsurprisingly, the new competing school attracted more students because the local faculty members there were well known in the community. The Medical Society, by contrast, had replaced the faculty at the original school with physicians from the North whom students distrusted and ridiculed. The old school charged that the Northern professors were mistreated because of political bias and that their presence at the school “called forth severe and illiberal attacks from several presses of the interiors, and every advantage was taken of political prejudices and passions.”⁴⁸ Most of the Northern faculty resigned soon after their first semester. Consequently, while the Medical Society school had only seven students in the first year, it enrolled around twelve students during the second year, and eighteen and twenty-two students between years three and four. Meantime, the faculty of the new school claimed to have been critically “assailed” by the Medical Society school.⁴⁹ Still bitter about the need to begin anew, its faculty said that the Medical Society only wanted control over the original school when it proved successful, which it had been, though “unnoticed by its nominal Trustees of the Medical Society, to the unhappy moment, when having become an object worthy of their jealous attention, it fell under their withering patronage and sunk at once into premature decay.”⁵⁰

With the division between the schools, the Medical Society and the faculty of the new school had to hone their public images to justify their respective positions in their feud. To that end, James Moultrie gave a speech in December 1835 entitled *Memorial of the State of Medical Education in South Carolina*, in which he claimed to have been called on by the press of the state and the South Carolina Society for the Advancement of Learning to give a historical account of

⁴⁸ *Ibid.*, 23.

⁴⁹ See S. C. Grimke, “Statements,” viewed at Addlestone Library and Archives, College of Charleston, Charleston, South Carolina, R 15 S6 S72.

⁵⁰ *Ibid.*, 3.

medical education in the state.⁵¹ Citing the history of the establishment of medical schools in South Carolina, Moultrie framed the problems of medical education as the fault of medical societies. He then laid out several problems that had plagued the original medical school when he was part of the faculty. He said first that the time allowed for lectures was too short for students to obtain adequate information. Secondly, there were not enough professors. The policy at the school had been to fill “professorial vacancies as they arose.” Yet, Moultrie noted, “As the elections are at present conducted, the trial of professorial skill comes after, instead of before an appointment, when it is frequently too late, or exceedingly inconvenient or embarrassing, to remedy the evils that are continually happening.”⁵² He also pointed to problems with examining the students, inadequate tuition, student behavior, and new students simply being unprepared for school.

After waxing long on each branch of medicine and spouting platitudes about medical education, Moultrie got to his point, which was that the state government should take control of medical education from the Medical Society. “Let the Legislature take the *whole subject* of education under its paternal care,” he suggested; “and let the system be regulated in accordance with the reviews and principles which have been exposed. Let the medical department be made a branch of that system, and a college be established by its authority; and let all other grants be abrogated, or expire naturally, at the end of the term for which they were given.”⁵³ He called for new buildings and better pay for professors, fewer students with better credentials, and wider general support for the medical school. Two years later, another former faculty member of the

⁵¹ James Moultrie, *Memorial of the State of Medical Education in South Carolina* (Charleston, SC: Burges & Honour, 1836), 3.

⁵² *Ibid.*, 7.

⁵³ *Ibid.*, 28.

old school, Joshua Whitebridge, gave a speech further praising the new school for its small classes, which offered better access to demonstrations and more attention from professors.⁵⁴

Not everyone viewed the problems of medical education as having the same cause. In 1838, Thomas Y. Simons, who was dean of the Medical Society school, responded to Moultrie in his introductory lecture to start the academic year.⁵⁵ After the general framing of what it took to be a good physician (which required education in each branch of the medical arts), Simons proceeded to praise the Medical Society as chief medical authority in South Carolina. “We have been called upon by our peers, the members of the Medical Society, to perform a high and responsible duty,” he declared, “a society founded by our forefathers, securing to us great and important rights, and which has been the regulator of the medical code of our state.”⁵⁶ Simons himself had been president of the society, which clearly determined whose side he would pick in the divide. “We are proud to be the representatives of such a corporation,” he told the few students in attendance. “We will not speak of our own capabilities, that would be indelicate; we will endeavor faithfully to discharge our trust, and leave it to others to decide upon our merits.”⁵⁷

Simons, who was also the Professor of Theory and Practice of Medicine at the old school, tried to blame all these problems on the faculty who started the new school. Specifically, he blamed their flight for the precarious state of the original school. “When the former Professors withdrew from this institution, those who were elected to fill their stations, commenced the

⁵⁴ J. B. Whitridge, “An Address to the Candidates for the Degree of Doctor of Medicine, Delivered at the Annual Commencement of the Medical College of South Carolina, March 15th, 1837,” *Southern Literary Journal and Magazine of Arts* 1 (1837): 241-250. In this case see page 243.

⁵⁵ Simons, *Introductory Lecture*, 26

⁵⁶ *Ibid.*, 21.

⁵⁷ *Ibid.*, 21.

performance of their duties under the most disadvantageous circumstances.” He also accused the faculty of starting rumors that the old school was going to close.⁵⁸ Simons dispelled rumors that the entire faculty of the Medical Society school was made up of outsiders from the North, saying “All of the present Professors are now resident physicians and practitioners of Charleston, and there is no longer any just ground for the rumor that the College cannot continue to progress.”⁵⁹

Attempting to end on a high note, Simons concluded, “We do not envy [the new school] their success; we have no desire to pluck from them one laurel which may encircle their brows. We are resolved to go on steadily and perseveringly, and will endeavor to go on steadily and perseveringly, and will endeavor to be collaborators in the great cause of medical and scientific knowledge.”⁶⁰ Whether Simons really wanted this outcome is debatable, but the schools would come together eventually despite the divisions.

Ultimately it was the inability to attract enough students that drove the two schools back together in 1839, seven years after the split. They called their reconciled institution the Medical College of the State of South Carolina. The original faculty and the Medical Society continued to squabble over whose fault the split had been and who would retain power in the merger, but merge they did in hopes of advancing professional medicine in South Carolina. What further encouraged good behavior was the destructive force of competition for students to both schools. Both schools knew that the area could not sustain two medical colleges. Once merged, the original faculty was returned to their building, museum, and apparatus.

⁵⁸ Ibid., 24.

⁵⁹ Ibid., 24.

⁶⁰ Ibid., 25.

In Arkansas, the medical society had a contentious relationship with faculty in founding the medical school much like South Carolina, and it was equally unclear as to who had control over the school. The difference in Arkansas was that the medical society itself had deep divisions in its membership. Personal attacks on fellow physicians in Arkansas were just as common as elsewhere, and much like Kentucky and South Carolina, physicians would often make their arguments public. In a speech to the graduating class at Little Rock's medical school in 1897, Dr. William H. Miller spoke to the problems:

Be true to your profession, and to your brethren of the profession.... I am sorry to say that there is more jealousy and recrimination in the medical profession than any other of which I have any knowledge, but you cannot afford to be untrue. It is true that there is no vocation that affords such a harbor and shelter for the charlatan and pretender, as the practice of medicine.... Much of your practice will be under the cover of occlusion and secrecy, and you can bury your mistakes with no eye to scrutinize them.⁶¹

Medical journal publishers understood that they needed to portray the profession in a positive light, both to unite the medical community and to create a good impression on the lay community. In an 1880 issue of *Arkansas Medical Monthly*, a journal promoted by several members of the Arkansas medical society, an editorial emphasized the importance of the press as a unifying agent. It spoke of a "bond of intellectual union dependent upon the first, whose object is to disseminate among us the knowledge as discovered of those ideas best calculated to advance the interest of the general cause. Its ties are the medical press. Through its organization all the vitalizing principles which are generated among the brotherhood find circulation,

⁶¹ William H. Miller, "Appear in Oxford Gowns: Ovation at the Commencement Exercises of the A. I. U. Medical Department," *Arkansas Gazette* (1897), 6.

affording nutrition, and propelling our advancement.”⁶² The editorial went on to call for reforms in medical ethics and stress the importance of medical education. “We are in favor of advanced medical education, and of laws to protect the people and profession from the outrages of charlatanism.... We desire this year to mark the era of university harmony in our ranks.”⁶³

Despite seemingly understanding the importance of professional unity, journal editors could not resist opportunities to point out the perceived wrongdoings of local doctors. An *Extra* edition of the *Arkansas Medical Monthly* in 1880 criticized select Arkansas physicians. “In the creation of this journal and the assumption of its editorial management,” the editorial apologized, “we did not anticipate such unpleasant duties as on this occasion we find ourselves obligated to perform. This disagreeable task consists in making known to the profession the following facts, which reflect discreditably upon persons whom we would rather believe to be above approach.”

The *Arkansas Medical Monthly* also focused its criticism on the Medical Department of the Arkansas Industrial University, and being the most important medical publication in the state, the criticism carried weight. The editor apologized for his bluntness, since many of the faculty of the medical department were personal friends, and he wanted the school to succeed. “Our sense of duty, however,” he insisted, “as the editor of the only medical organ in the state, was appealed to by the flagrant discrepancies which were manifest in their organization and we could not honorably resist the temptation to criticize them.”⁶⁴ Most damningly, he argued that the medical department should not be admitted to the American Medical College Association because its faculty was not properly educated, nor were many of them “regular” doctors. The

⁶² “Editorial,” *The Arkansas Medical Monthly*, 1 (1880), 32.

⁶³ *Ibid.*, 33.

⁶⁴ “Extra,” *Arkansas Medical Monthly* 1 (1880): 2. See also Articles of Association & Charter, University of Arkansas Medical Department, 1879.

editor had also learned that the American Medical College Association did not count the Medical Department of the Arkansas University as a member, even though the school had publicly claimed membership.⁶⁵ “So wicked a deception” demanded explanation.⁶⁶

The *Arkansas Medical Monthly* went on to suggest that even teaching medicine at the school was a violation of the land grant that the University of Arkansas had received in 1862. “It will be observed that medicine was not a course of study,” the editor charged, “and indeed could not be, as it would be foreign to the object and purpose of the congressional donation.”⁶⁷ He hoped a new, legal, medical school would be established, but the existing school might first have to be dissolved. “We proposed not to prosecute them any further if they would make proper acknowledgement of their wrong; dissolve the present relations of the college with their stockholders’ association, and enter into a legal organization for a legitimate purpose, with a faculty chosen for their professional merit, independent of any property qualification,” the journal stated. “We think the profession of the state will demand as much.”⁶⁸

The *Arkansas Medical Monthly* dissect the uneasy relationship between local physicians, the medical society, and the medical school. Since so many physicians in the Arkansas medical society were responsible for the creation of the *Arkansas Medical Monthly*, it is no surprise that the journal praised the medical society.⁶⁹ The medical society also praised the *Arkansas Medical Monthly*, and Philo Hooper, one of the physicians responsible for developing both the medical

⁶⁵ *Ibid.*, 2-3.

⁶⁶ *Ibid.*, 3.

⁶⁷ *Ibid.*, 4.

⁶⁸ *Ibid.*, 12.

⁶⁹ “Editorial,” *Arkansas Medical Monthly*, 89.

school and the medical society praised the journal for working for the progress of “organized medicine,” AMA sponsored legislation, and the medical society.⁷⁰

What was not always clear was whether the *Arkansas Medical Monthly* directly supported the medical school. The journal continued to have shifting viewpoints about the school, although, perhaps out of loyalty to Philo Hooper, it praised the school as often as it criticized. In considering reports about medical diploma mills in other places, the journal countered that the medical school in Little Rock had “certainly met with extra ordinary encouragement in its first session, and we trust it will soon take rank among the best medical education institutions in the land.” But the journal also complained that there were not enough faculty at the school. “Only eight chairs are represented upon its faculty,” it revealed, “which number is, in our opinion, insufficient to encompass properly all the departments in medicine.”⁷¹ In a later issue, the monthly editor returned to criticizing the faculty directly, saying that one of them, “a druggist,” had hired another worker who was “a non-practitioner” to give the lessons to the students. The journal further attacked the professionalism of the school, saying, “We have nothing to urge against the competency of any of these gentlemen, but do insist that the entire proceedings were most extraordinary and totally inconsistent with the principles supposed to govern us as a brother-hood of doctors, and incompatible with the laws of organized medicine, of which we all claim to be exponents.”⁷² Because of the embarrassment of these inconsistent positions, the medical school ultimately stopped advertising in the journal.

⁷⁰ *Ibid.*, 90.

⁷¹ *Arkansas Medical Monthly*, 1 (1880), 135

⁷² “Home News,” *Arkansas Medical Monthly*, 143.

The *Arkansas Medical Monthly* also voiced the frustrations of medical practitioners in Little Rock who were not able to invest or participate in the founding of the school. The journal noted, “It is claimed that these gentlemen were prompted by unselfish motives in this organization, being only desirous of starting the school, at a time when others were unwilling to invest in the enterprise.”⁷³ Yet, the journal also questioned how anyone could know if this was true, since there had been a limited number of faculty positions and none of the other physicians in Little Rock were consulted about the school. Whatever the issues, the journal did not believe it could overlook any of the school’s problems. It had “sworn to protect and uphold” the medical profession, and did not want the school to become “a glaring insult to the profession of this city and of the State of Arkansas.”⁷⁴

Yet, *The Arkansas Medical Monthly* was not above publishing satirical stories that mocked the medical school and medicine in Arkansas. For instance, in the article “How Our School Makes Doctors,” a fictitious doctor Josephus Elenorus Knslow, who was “Professor of Diseases of the Umbilicus in the Dreamtown Medical College,” started a school with a small number of doctors that was suspiciously like the Medical Department at the Arkansas Industrial University. The locals, which “as any medical student” knew, furnished the clinic with its “occasional material,” operated “several groceries where powder and coal oil” were sold. The rest were farmers who ran threshing machines. The medical school, to its credit, did not count itself a member of the American Medical College Association, but it would take female as well as male students into the school, and the school did not much care about their character.⁷⁵

⁷³ Ibid.

⁷⁴ Ibid.

⁷⁵ “How Our School Makes Doctors,” *Arkansas Medical Monthly*, 1 no. 7 (1880): 330-31.

Despite the shifting nature of support for the school in the *Arkansas Medical Monthly*, coverage in the state newspapers was often positive. Stories promoting the potential of the school and its positive contribution to the profession were regularly published. On September 4, 1879, the *Russellville Democrat* reported, “The college is started under the auspices of the Arkansas Industrial University, and we doubt not, will receive the aid of our State government, the cordial support of the medical profession, and of all our people. Success to our home institute!”⁷⁶ Materials about the success of graduates from the medical school made it as far North as New York, with accounts of commencement and graduates circulated in journals like the *New York Medical Journal: A Weekly Review of Medicine*. In 1883, it reported, “We are indebted to a correspondent for a copy of the “Daily Arkansas Gazette: of the 1st inst., in which we find an account of the commencement of the Medical Department of the Arkansas Industrial University.”⁷⁷

The Medical Department promoted itself in print. For instance, the *Transactions of the State Medical Society of Arkansas* often published reports by the Board of Visitors concerning the department. In 1889, a Dr. Hart gave a report that was mostly positive, touting the accomplishments of the Medical department and exulting the “high standing” of the Medical Department in the community: “It has continued to increase in prosperity since our last report. We are more than ever impressed with the increasing usefulness of this institution. A general

⁷⁶ *The Russellville Democrat*. September 4, 1879. *Chronicling America: Historic American Newspapers*. Lib. of Congress. <https://chroniclingamerica.loc.gov/lccn/sn84023017/1879-09-04/ed-1/seq-2/>

⁷⁷ *The New York Medical Journal: A Weekly Review of Medicine*, 37 (1883): 308.

survey of its condition can but afford great satisfaction to the friends of medical education throughout the State.”⁷⁸

The state medical society at times wanted to communicate to the community that it believed in the medical school and claimed it as an extension of its own work. It fully embraced the school in 1890 with the print declaration in the *Journal of the Arkansas Medical Society* that the school “should be the especial pride and admiration of very reputable physician living within the State. While this college may not be an offspring of the Society, strictly speaking, yet it is an adopted child, and, as far my knowledge extends, the only medical institution in the land that is watched over and its work investigated by committees from a State Society.”⁷⁹ The president’s annual address, given by Zaphney Orto, noted the importance of the medical school in treating Southern diseases. “It is in this college that our youth are prepared and made fit to grapple with diseases peculiar to this climate and country, and not this only, but armed and equipped, second to none, in the science and practice of our profession in all its branches and details.”⁸⁰

The medical society also promoted the school’s high standards of admission and effectiveness in the community: “Medical students, and all others interested in medical education, are assured that every advantage offered by distant colleges are afforded by the Medical Department of the Arkansas Industrial University, without the serious objections inherent to all overcrowded schools,” it declared.⁸¹ The students did not have to go far away from their home state to get a good medical education, nor to a foreign country. The medical

⁷⁸ *Transactions of the State Medial Society of Arkansas*, 12-14 (1887): 11

⁷⁹ *Journal of the Arkansas Medical Society*, 1 (1890): 4.

⁸⁰ *Ibid.*

⁸¹ *Transactions of the State Medical Society of Arkansas*, 12-14 (1887): 11.

society claimed to believe in the importance of medical schooling. “Knowledge brings desire for more knowledge, and a young man well trained in the various branches of medicine are taught in our reputable medical colleges needs no further stimulus to extend his learning than the desire already begotten in him to emulate those masters in medicine and surgery who have fired his mind with a love and zeal for profound medical lore.”⁸² The report noted that many “post-graduate colleges” had employed Arkansas health practitioners.

The three states that form the basis of this study demonstrate the complicated nature of professional medicine in the South. Physicians, medical societies, and different communities wanted to promote the success and grandeur of medical education, even as many of the physicians and associated groups also undermined that goal. Physicians attacked each other because of perceived threats to their reputation or honor, and they did this despite the risks it posed to the success of the schools themselves. Rivalries grew to such intensity that rival physicians attempted to create competing schools. Medical societies both helped to found medical schools and actively criticized them, often attempting to assert power over the institutions to the detriment of the public good. Ultimately, the successful schools were the ones that attempted to create harmony within their faculty, with their medical societies, and with their fellow practitioners. Not just medical education, but also the professionalization of medicine depended on establishing a united front among doctors, a fact that would become increasingly clear in the reforming impulse that developed at the turn of the century, a time when each of these schools would stand on the brink of ruin.

⁸² Ibid., 14.

V. The Perception and Politicization of Cadaver Dissection

When Charleston's first medical college opened in the 1820s, it was riding a wave of popularity and competition among medical schools in the South. The faculty, proud of their early success in attracting students, commented in their faculty minutes on May 2, 1825 that the school would be successful because of its location:

No place in the United States offers as great opportunities for the acquisition of Anatomical knowledge, subjects being obtained from among colored population in sufficient number for every purpose, and proper dissection carried on without offending any individual in the community. Those impediments which exist in so many other places, to the prosecution of this study, are not here thrown in the path of the Student, public feeling being rather favorable than hostile to the advancement of the Science of Anatomy. In addition, the Southern Student can nowhere else receive correct instruction on the disease of his own climate, or the peculiar morbid afflictions of the colored population.¹

The story of medical dissection in the South is bigger, however, than just the medical schools that drew students with a plethora of cadavers. Throughout the nineteenth century, medical schools in both the Northern and Southern regions of the United States required a regular supply of bodies for medical study and experimentation, and physicians and medical students targeted the bodies of African Americans, both freedmen and slaves, to meet this demand. Simultaneously, the nation's booming newspaper market became a stage on which divisive debates about the cruelty of slavery and the social consequences of pursuing scientific

¹ Carolyn B. Matalene and Katherine E. Chaddock, *Vital Signs in Charleston: Voices Through the Centuries from the Medical University of South Carolina* (Charleston: History Press, 2009), 17.

advancements and medical knowledge played out in articles about the dissection of black bodies. Northern and Southern newspapers published stories about dead bodies as both serious scientific news and salacious entertainment, to sell more newspapers. Both Northern and Southern newspapers capitalized on stories of dissected black bodies for whites to have their anatomical questions answered and their morbid fascination quelled.

An example of this is Joice Heth, a slave and member of P.T. Barnum's "Freak Show." Because of her supposed lifespan of 161 years when she died in New York City, Barnum saw an opportunity to draw a final crowd with a dissection of her body in front of over fifteen hundred people paying fifty cents apiece. Newspapers cheerily covered the story in detail, questioning whether it was truly Heth's body being dissected and whether the doctor, the *New York Sun* newspaper editors covering the event, or Barnum would receive the largest share of profits from the display. "What would Dr. Rogers and the Sun people give us for a couple of good old negro wenches that must die soon?" The *Herald* asked. "They are as old and ugly as Aunt Nelly, and will *postmortem* the public admirably."² The description of Heth's exposed body echoed scenes of the slave auction block, in which the "soundness" of the captives for sale was demonstrated by means of invasive pseudo-medical examinations conducted by potential purchasers.³

The ways in which editors, journalists, and readers perceived this cadaverous content and related commentaries, especially as it pertained to African American bodies, reflected scientific and popular attitudes towards slavery and race.⁴ In particular, Southern newspapers reaffirmed

² "The Joice Heth Hoax," *The Herald*, February 29, 1836.

³ Britt Rusert, *Fugitive Science: Empiricism and Freedom in Early African American Culture* (New York: New York University Press, 2017), 118.

⁴ As Daina Berry comments in *The Price for Their Pound of Flesh*, "Physicians in both regions worked together to develop a domestic cadaver trade. Perhaps the quest for medical knowledge trumped regionalism." Daina Ramey Berry, *The Price for Their Pound of Flesh: The*

perceived racial hierarchies with stories about dissection, in which white anatomists possessed the black body through full ownership in life and medical knowledge in death.

Americans' fascination with dead bodies and human dissection in the nineteenth century ensured that such stories increased newspaper sales. Significantly, editorial and journalistic choices juxtaposed a cultural fascination with death against commonly held fears about falling victim to the barbarous activities of medical schools, a terror that struck Americans from all social and racial categories in this period. When newspaper articles focused on black anatomized bodies, it placed dissection in a safe context for white readers because they felt less threatened themselves. White readers, moreover, were more than merely titillated by news items about dissected bodies: They learned about human anatomy and increasingly appreciated its value as an essential part of scientific discovery and medical training. In an unsurprising contrast, such stories increased fears about dissection and mistrust towards the medical profession among African American communities, which manifested in riots against physicians, vandalism against medical schools, and corrective responses from African American newspaper editors and journalists.

The story of Nat Turner's revolt is a fitting example of how Northern and Southern newspapers debated dissection in the nineteenth century, as Southerners dissected Turner's body and Northerners accused Southern medical schools of oppression. Anatomists dissected Turner in accordance with laws that allowed the dissection of executed criminals, but newspaper accounts of the leader's death and dissection showcased broader attitudes towards race relations in the sections. One Southern journalist joked that "General Nat" had traded his body for spare

Value of the Enslaved from Womb to Grave in the Building of A Nation (Boston: Beacon Press, 2017), 169.

change and had “spent the money in ginger cakes.”⁵ Thirty years later, William Lloyd Garrison’s Boston-based, abolitionist newspaper ridiculed accounts of the prisoner selling his body for food. “It does not appear probable, from the known habits of Southern anatomists,” the *Liberator* claimed, “that any such bargain could have been needed.” The paper argued that Southern medical schools had a long history of acquiring black bodies for dissection and quoted doctors who boasted that the South’s black population allowed students a wealth of opportunities for anatomical investigation: “What a convenience, to possess for scientific purposes a class of population sufficiently human to be dissected, but not human enough to be supposed to take offence at it!”⁶ When the *Liberator* made these accusations, its argument was political and made a clear charge before the public that Southerners believed they owned black bodies, living and dead.⁷ If the act of dissection sent a message about control of black bodies, newspaper coverage and interpretation of dissection conveyed that message to the general public.

Through an extensive examination of nineteenth-century newspapers, this chapter identifies specific themes that were evident in coverage of dissection during this period. First, they show how dissection stories about African Americans created conceptual room for a new popular interest in scientific and medical innovation among white audiences without amplifying fears that they might become victims themselves. Next, they demonstrate how Southern

⁵ “Nat Turner,” *Norfolk Herald*, November 14, 1831.

⁶ “Nat Turner’s Insurrection,” *Liberator*, August 9, 1861.

⁷ Franny Nudelman illustrates how “penal dissection undermined the rituals and beliefs that gave death its spiritual and social significance” and were a “form of racial violence used during the antebellum period to terrorize African and Native Americans and justify their continued subjugation.” See Franny Nudelman, *John Brown’s Body: Slavery, Violence, & the Culture of War* (Chapel Hill: The University of North Carolina Press, 2004), 40-41. Nudelman notes that, instead of dwelling on the dissection of black bodies, abolitionist newspapers focused more attention on the living words of executed slave revolt leaders, publishing their letters to loved ones. “Last Letter of Young Copeland,” *Oberlin Evangelist*, January 4, 1860.

newspapers, especially, crafted stories of dissection that served the dual purpose of entertaining white readers and humiliating African Americans. This public humiliation, writ large in national news coverage, fostered what became a popular genre of derogatory and vile humor that reinforced negative and inaccurate racial stereotypes. Third, newspapers illustrate how stories about the dissection of African Americans cultivated and perpetuated racist science in this era. Finally, they show how aspects of such newspaper coverage provoked various reactions within black communities and among anti-slavery advocates. Newspaper rhetoric around these themes amplified tensions between religious and scientific perspectives, reflected differences and similarities between the North and South, and fortified racist views in both cultural and scientific contexts.

Newspaper analysis of dissection allows for new understandings of the perception, progress, and limitations of medical education in this era as well as the relationship between black bodies and Southern medical education in the United States. Because cadaver dissection was a pivotal form of doctoral training but also a sensational concept to the public less familiar with medical education as a whole, dissection came to represent fears about death but also uncertainty about the intentions of doctors and medical universities. While it is clear to modern readers that opportunities for dissection and clinical experience produced more capable physicians, this was not as widely understood in the nineteenth century, when appeals for bodies and experimental material seemed morbid. Especially to those like African Americans whose bodies were most vulnerable, medical education did not have an entirely positive connotation. Experimentation by physicians like South Carolina's J. Marion Sims who targeted the marginalized of his community, African American women, to advance understandings of concepts like gynecology and obstetrics leave a dark mark which prevents historians from seeing

developments in the history of medicine and medical education as wholly progressive. This chapter showcases that darkness. Southern medical schools and Southern doctors of the nineteenth century, while they did lay a foundation of medical understanding for future doctors, also laid a firm foundation of distrust among the poor and marginalized of their communities.

Several historians have shown how the dissection of black bodies by physicians and medical students reinforced notions of racial inferiority—specifically, the power of white persons to control the bodies of African Americans in life and in death. Newspaper coverage of dissection also allayed fears among white readers by insinuating that black bodies were required to advance science and medicine. Using newspapers as the primary lenses through which to view the relationship between medical education and the exploitation of African Americans also showcases and adds to the scholarship on the diverse social, intellectual, and political movements within African American communities in the nineteenth century. As medical education advanced at the expense of black bodies, fears of dissection escalated among black audiences and instigated specific responses from African American leaders and writers. Historian Derek Spires argues that black writers in pamphlets and newspapers defined citizenship and equality according to what individuals do, rather than ethnic identity. On the eve of the Civil War, for example, black writers encouraged fellow African Americans to resist slavery violently, defend their homes and property, and demonstrate their intelligence emphatically, all of which were described as worthy acts of American citizenship.⁸

The general public in the nineteenth century distrusted anatomists, and the attempt by physicians to control understandings of anatomy further created a national taste for dissection

⁸ Derrick R. Spires, *The Practice of Citizenship: Black Politics and Print Culture in the Early United States* (Philadelphia: University of Pennsylvania Press, 2019).

even as it escalated public terror that made procurement of cadavers more difficult.⁹ Much of the fear of dissection came from a belief that bodies must remain intact to enter heaven, but medical men argued that opposition to dissection grounded in religion reflected a misunderstanding of teachings on resurrection, which actually reinforced the concept that the soul and the body were not connected and that the body was meant for decay. Physicians were not advancing a secular society, but instead hoped to eliminate doctrinal misconceptions among believers.¹⁰

At the same time, limited access to cadavers forced medical schools to compete with each other for bodies and for students. Institutions advertised “material of dissection abundant,” reinforcing the fact that bodies could be hard to acquire and that aspiring anatomists must pick schools that supplied them.¹¹ Even leading medical schools, such as Yale and Columbia continued to struggle to procure cadavers for dissection, which kept them from offering anatomy courses until 1846.¹² The passage of anatomical acts made possible the professionalization of medicine and science in part by sterilizing the process of dissection by taking it out of the realm of the sensational. These laws ended sensational and grotesque practices like skinning heads which added protection for dissectors obtaining bodies illegally. The end of secrecy surrounding

⁹ Mary Schwanz argues that anatomists held new and controversial beliefs about how the body worked and its place in religion, forming an intellectual cohort separated from the general public. Mary Patricia Schwanz, “A Culture of Anatomy: The Public Writings of American Anatomists, 1800-1870,” (MA diss., James Madison University, 2015), 1-2.

¹⁰ Tiffany DeRewal, “The Resurrection and the Knife: Protestant Cadavers and the Rise of American Medicine,” *Literature and Medicine* 32 (Fall 2014): 391-392. Jonathan Sawday explains that many Christians believed “denial of burial involved the punishment of the soul” in *The Body Emblazoned: Dissection and the Human Body in Renaissance Culture* (London: Routledge, 1995), 280.

¹¹ “Hahnemann Medical College and Hospital,” *Northern Tribune*, January 21, 1882.

¹² Harry Bloch, “Human Dissection: Epitome of Its Evolution,” *New York State Journal of Medicine* 77, no. 8 (1977): 1341.

those who practiced dissection aided in the growing acceptance of dissection and the process of physician detachment from cadavers.¹³ Pennsylvania's legislature passed the first anatomy act which allowed the dissection of unclaimed bodies in 1867, but other states lagged behind. Bodysnatching continued in force throughout the century, even though most Northern states had passed acts against it by the 1890s. The South continued to hold out, but by 1913, only Alabama, Louisiana, and North Carolina had failed to legalize dissection in some form.¹⁴

Doctors pled their case for the need of dissection to the public, and American newspapers reprinted facts and stories about dissection in other countries, many of which, they implied, were more culturally and religiously open to dissection than the United States. The *Topeka State Journal* reprinted Dr B.W. Roby's call for bodies in 1895. He complained of a public that "demands of all medical men an ample and intimate knowledge of all the physical sciences" yet "bars the doors to such knowledge and makes it a crime to obtain it surreptitiously." The *Charleston Mercury* reprinted an article about the problems of overcrowding in London cemeteries in which a surgeon argued that, because the soul left the body upon death, what happened to mortal remains did not matter. He explained the scientific process by which all bodies would rot anyway and praised an executed man who, through dissection, could rejoice in his body serving a higher purpose—the advancement of medical knowledge for those still living:

¹³ Venetia M. Guerrasio, "Dissecting the Pennsylvania Anatomy Act: Laws, Bodies, and Science, 1880-1960" (Ph. D. Dissertation, University of New Hampshire, 2007), 207-231.

¹⁴ Michael Sappol, *A Traffic of Dead Bodies: Anatomy and Embodied Social Identity in Nineteenth-Century America* (Princeton, N.J.: Princeton University Press, 2002), 316-318. Shauna Devine suggests that the availability of material for dissection in the Civil War led to the progression of the medical sciences and precipitated more states passing the acts in *Learning from the Wounded: The Civil War and the Rise of American Medical Science* (Chapel Hill: University of North Carolina Press, 2014), 7-8.

“Thank you, my Lord,” the criminal could say, “It is well you cannot dissect my soul.”¹⁵

The three Southern medical schools discussed in this study certainly made attempts to convince students and the public that dissection was incredibly important. From the start of the school year, students were reminded of the significance of seeing human subjects. In Samuel Henry Dickson’s speech to the graduates of the Medical College of South Carolina in 1825, he proclaimed that the aspiring student “should, *in the first place*, have admission to a sufficiently extensive collection of anatomical preparations, and should be carefully instructed in the art of dissection. This latter point he should consider an essential prerequisite; for without access to recent human subjects, and without a familiar acquaintance with the use of the knife he cannot become an Anatomist, a surgeon, an Accoucheur or a Physicians.” Dickson was solemn on this topic, admitting, “on this rock, more than one of the Medical Schools of our country are doomed to split.” Dickson went on to complain that students were often restricted by necessity to anatomical models instead of cadavers, but nothing could make up for the “natural and morbid state of a part.”¹⁶ Thomas Cooper agreed, arguing, “The most strenuous attention should be paid to anatomy, physiology and the practice of surgery, with a repetition of private dissections, till the practice of dissection is perfectly familiar, and the dexterity habitual.” He also suggested that two years was not enough time to study dissection, and that more practice was needed beyond medical school.¹⁷

Because the state reserved dissection for executed felons as another horror meant to deter

¹⁵ “Burning and Burying,” *The Charleston Mercury*, October 1, 1857.

¹⁶ Samuel Henry Dickson, *Introductory Lecture Delivered at the Commencement of the Second Session* (Charleston, SC: W. Riley, 1826), 10.

¹⁷ Thomas Cooper, *Address to the Graduates of the South Carolina College, December 1821* (Columbia: D. Faust, 1821), 11.

people from lives of crime, the idea that physicians could mutilate the body and examine it in such a public manner in a kind of post-mortem torture appalled people. Yet newspapers could discuss the dissection of those condemned for crimes as a continuing marker of shame that made the act of dissection justifiable. As long as dissection served as a punishment and only on executed bodies, it could be openly discussed.¹⁸ States gave medical schools the bodies of executed criminals, but American anatomists bemoaned the fact that governors signed so few death warrants. Nor could doctors legally import bodies from states more amenable to dissection since laws policed the shipping of dead bodies.¹⁹ The bodies had to come from somewhere, and newspapers loved to talk about how medical students gathered them.

Anecdotes about the horrors of dissection abounded in the North and South, scaring and fascinating audiences with descriptions of dissecting rooms and the vulnerability of the dissected corpse. Newspapers conjured up images of rotting cadavers piled everywhere, carved and disfigured under the leering eyes of students. Referring to the place of dissection as the “deadroom,” one paper detailed how “a small army of students...slowly work away the nerves and arteries and muscles of the bodies, till finally the grisly shapes disintegrate.”²⁰ The *Philadelphia Inquirer* published a lengthy article describing every aspect of the dissecting room down to the tables that “run with the juices of the body, which trickle down drop by drop into the pans, making a mournful dirge for the dead.”²¹ Historian Michael Sappol argues that growing

¹⁸ Aaron D. Tward and Hugh A. Patterson, “From Grave Robbing to Gifting: Cadaver Supply in the United States,” *Journal of the American Medical Association* 287, no. 9 (March 2002): 1183.

¹⁹ “Must Have Dead Bodies,” *Topeka State Journal*, December 28, 1895.

²⁰ “Model Dead House,” *Topeka State Journal*, February 1, 1898.

²¹ “City Intelligence: The Dissecting Room,” *The Philadelphia Inquirer*, July 27, 1871.

interest in the macabre in general and anatomy and dissection specifically spawned a genre of serial novels that centered on the gruesome mutilation of the innocent dead. These novels hinged on the trope of the powerful devouring the powerless in pursuit of knowledge, wealth, or lustful desires.²² In *A Traffic of Dead Bodies*, Sappol blends his literary investigations with a cultural analysis that places the poor and the black at the mercy of anatomists both in fiction and in reality. Another scholar, Ludmilla Jordanova's in *Sexual Visions* explores the eroticism of dissection, often depicted in images and prose in the nineteenth century, as male doctors probing a female corpse. Physicians undressed powerless bodies both physically and scientifically. Newspapers talked of women rescued from the dissecting table by their lovers or of medical students falling in love with their beautiful cadavers. In cases of white women, reports often commented on the attractiveness or of past dignities they had suffered.²³

Fears of dissection exacerbated by newspaper coverage created tensions between medical schools, physicians, and the general population, and medical schools struggled to distance themselves from scandal. It was well-known that medical students and faculty members took risks in grave robbing that could cost them their lives. Daniel Drake worried that the opening his school in Cincinnati would depend on procuring bodies from a "potter's field."²⁴ Sometimes family members of cadavers took legal action against physicians or schools who retrieved the

²² Michael Sappol, "'The Foul Altar of a Dissecting Table': Anatomy, Sex, and Sensationalist Fiction in Mid-Nineteenth-Century America," *Transactions & Studies of the College of Physicians of Philadelphia* 20 (1998): 67-68.

²³ Ludmilla Jordanova, *Sexual Visions: Images of Gender in Science and Medicine between the Eighteenth and Twentieth Centuries*. New York: Harvester Wheatsheaf, 1989), 97-110. See also, Katherine Park, *Secrets of Women: Gender, Generation, and the Origins of Human Dissection* (New York: Zone Books, 2006).

²⁴ Daniel Drake Letter, February 14, 1819, Samuel Brown Papers 1817-1825, Mss. A B881, Special Collections, Filson Library, Louisville, Kentucky.

bodies of loved ones in an unsavory manner. A woman sued the Medical College of Georgia for \$25,000 for stealing the body of her husband who had died in the jailhouse on his way to the insane asylum. The physicians in question defended their actions by arguing that the husband had a rare form of insanity and that “the discoveries made in dissection” contributed “to the eminent welfare of science.”²⁵ The *Salem Gazette* recounted how police caught a medical student attempting to carry away a body from a potter’s field and sentenced the student to six months in prison. The paper cautioned, “The young gentlemen attending the medical school of this city, will take warning by this man’s fate” if they, too, are “found violating the law and decency of Christian burial.”²⁶ When a doctor, a druggist, a medical student, and the son of a brewer all conspired to steal the body of a recently deceased woman from her grave, a mob nearly lynched them before officers could lock them in jail to save their lives. When asked why they tried to rob the grave the doctor explained very plainly, “Things are just about this way. We are medical students at the Eclectic College. Before we can practice we have to graduate; before we graduate we must dissect, and before we dissect we have to have subjects to.”²⁷

The three medical schools in this study struggled to find cadavers, and that is especially evident with Kentucky’s Transylvania. The October 25, 1822 entry in their faculty minute book reflected how disputes over obtaining cadavers fueled disagreements among the professors. Professor Dudley who ran the anatomy classes complained in the meeting of the money he had personally paid buying cadavers for students. His frustration came mainly from the fact that the school looked the other way when students snatched cadavers, which allowed them to procure

²⁵ “Suing the Doctors Because They Dissected Her Husband’s Body,” *The Daily Picayune*, August 23, 1897.

²⁶ “Resurrectionists,” *Salem Gazette*, May 28, 1824.

²⁷ “Caught in the Act,” *St. Louis Globe-Democrat*, December 17, 1887.

their own dissection material without depending on the school to provide it. The faculty resolved that each student would pay five dollars extra in tuition to help Dudley pay for cadavers that he had furnished.²⁸

Where was Dudley getting the bodies? That can be cleared up by the memoir of a former Transylvania student that Dudley hired to procure bodies from local graveyards. Indeed, he claimed to be the professor's "only dependence in procuring subjects."²⁹ This suggests that Dudley wanted students to stop grave robbing not because it was unethical, but because they were competing with the medical school, which was losing money as a result. Students also were likely drawing too much attention to a practice that Dudley did not want publicized.

Rumors persisted that one of the reasons for Transylvania's ultimate failure as a medical school was that it could not furnish its students with cadavers. Students in 1838 acknowledged, "A report is abroad among the profession...that few facilities for anatomical study could be afforded us in this institution." They responded by writing a defense of the school's dissecting rooms. "All of us who have applied for anatomical material have been immediately supplied," they submitted, "[and] one half of the members have already enjoyed the advantages of private dissection." They described their dissecting subjects as "excellent," as well as being provided "at a very moderate price." A dissecting ticket was ten dollars and "may be taken or omitted, at pleasure." The students also talked about how friendly the citizens of Lexington were and how

²⁸ Transylvania Faculty Minute Book, 1819-1849, Entry of October 25, 1822, Transylvania University Special Collections, Lexington, Kentucky.

²⁹ J. Hill Hamon, *Two Letters Concerning the Early History (1817-1818) of the Medical College of Transylvania University* (Frankfurt, KY: The Whippoorwill Press, 1993), 19-21.

many surgeries the students had the opportunity to observe.³⁰ Eighty-four students signed the document. True or not, it was a good advertisement for the school in a time of heated competition for tuition dollars.

Some medical schools hoped to avoid outrage by passing resolutions punishing students who stole cadavers, but this did little to change the public's perception of the situation.³¹ Medical historian Frederick Waite has also argued that newspaper editors often worked with medical schools to hide their body snatching escapades, printing stories that blamed either the grave robbers and their desire for money or students from distant universities, rather than local medical institutions.³² Understanding that rumors about dissection abounded and hurt the profession, faculty members encouraged their students to observe discretion in such matters, at least publicly. John G. Coffin argued at the Massachusetts Medical Society, "A large and enlightened portion of the public are fully aware of the importance and necessity of a knowledge of the structure of the human fabric,...so far as the laws of decorum are observed, and the feelings of humanity strictly respected." He hounded medical schools for the stories of bodysnatching and cadaver abuse circulating. Coffin said that the snatching should be suppressed, and if that proved impossible, schools should "do themselves the justice at least of separating the guilty individual...from the body they were willing to dishonor."³³

³⁰ *Transylvania Medical Journal—Extra, Transylvania Catalogue of Medical Graduates, with an Appendix, Containing A Concise History of the School from its rise to the Present Time.* (Lexington, KY: Intelligencer Press, 1838), 29-34.

³¹ John Harley Warner, *Against the Spirit of System: The French Impulse in Nineteenth-Century American Medicine* (Princeton: Princeton University Press, 1998), 25-26.

³² Frederick C. Waite, "Grave Robbing in New England," *Bulletin of the Medical Library Association* 33 (1945): 272-294.

³³ John G. Coffin, *A Dissertation on Medical Education, and on the Medical Profession* (Boston: William L. Lewis, 1828), 37-38.

Newspapers reported black bodies being transported to a medical institution across state lines, especially when African American cadavers were moved from the South to the North. Passengers on trains sometimes found bodies packed and transported illegally for dissection. One paper reported that some men who stole a barrel of whiskey discovered upon drinking it that “the body of a negro preserved for dissection” was inside.³⁴ The School of Medicine of Maryland University faced investigation into its trade in corpses when the body of an apparently respectable woman showed up on a dissecting table. The event “excited much attention, comment and speculation,” as “the body was not the product of ‘Potter’s field’ or other place whence medical colleges are supposed generally to get their supplies of ‘subjects’ for dissection.” Commenting more broadly, the article noted, “That colleges do not generally depend on the product of cities in which they are situated for material for the dissecting room, is well known.” One man accused of transporting bodies was “reported as having shipped 25 barrels, each containing a doubled up body, from Washington to the College of Physicians and Surgeons” in Baltimore.³⁵ Both Todd Savitt and Stephen Kenny show that physicians in the South moved black bodies and case studies of them to physicians throughout the United States, thereby winning fame and respect from more prestigious universities.³⁶

³⁴ “New-England News of the Week,” *Woonsocket Patriot and Rhode-Island State Register*, May 19, 1865.

³⁵ “The Late Grave Robberies,” *The Sun*, December 3, 1880.

³⁶ Todd L. Savitt, *Medicine and Slavery: The Diseases and Health Care of Blacks in Antebellum Virginia* (Urbana: University of Illinois Press, 2002) and Stephen Kenny, “The Development of Medical Museums in the Antebellum American South: Slave Bodies in Networks of Anatomical Exchange,” *Bulletin of the History of Medicine* 87, no. 1 (Spring 2013): 32-62; “‘A Dictate of Both Interest and Mercy’?: Slave Hospitals in the Antebellum South,” *Journal of the History of Medicine and Allied Sciences* 65, no. 1 (January 2010): 2-47; “Medical Racism’s Poison Pen: The Toxic World of Dr. Henry Ramsay (1821-1856),” *The Southern Quarterly* 53, no. ¾ (Spring/Summer 2016): 70-96.

Small wonder African Americans were said to fear physicians and the medical professionals who targeted their bodies. The *St. Louis Globe-Democrat* published an article in which the writer traveled throughout the South to study black superstitions. Fear of dissection made the list alongside beliefs in witchcraft and necromancy. He noted that Southern blacks had a curious anxiety about medical students which “becomes a madness of fear and exaggeration,” and it was “with sad logic that the Mississippi black reasons that the subjects for this ghastly use will be taken from the negro ranks.” Fear of dissection resulted from rumors circulating when any person came to town who might be mistaken as a visiting anatomist in training. Calling the beliefs “delusions,” the traveler noted that they took hold in the black population because of their inherent ignorance and their naivety.³⁷ When the circus came to town in Richmond, Virginia, a paper reported that blacks in the town operated under a self-imposed curfew for fear of being caught by anatomists. The excitement started when a rumor that “forty medical students from New York” had come to the Southern city to gather subjects from the black population there.³⁸ One black man in Lexington, Missouri similarly warned his friends and family to stay off the streets at night when he told them of his harrowing escape from a student doctor he claimed had tried to overpower him. The paper mocked him for sticking to “his preposterous original story,” but noted that the rumor was effective in curtailing the nighttime activities of the blacks in town.³⁹

While newspapers generally criticized dissection stories about whites for being disrespectful, white audiences found stories about the dissection and mutilation of black bodies

³⁷ “Black Superstition,” *St. Louis Globe-Democrat*, November 12, 1885.

³⁸ “Ridiculous Rumor in Richmond,” *Milwaukee Daily Sentinel*, November 21, 1867.

³⁹ “Badly Scared Darkies,” *Butler Weekly Times*, December 19, 1888.

humorous. Historians Harley Warner and James Edmonson's collection of photographs from the dissecting table showcases the macabre sense of playfulness that medical students had with their cadavers, but anecdotal stories made sport of African American fears of death and dissection.⁴⁰ A New Orleans newspaper introduced a dissection story, supposedly from Georgia, because it was "brimful of fun." The article told about an African American boy named Jake whose master was a physician. The doctor bet his dinner guests that his slave was brave enough to retrieve a head from the dissecting room only to have a ventriloquist at the dinner hide behind the bodies and scare the boy.⁴¹ The *Charleston News and Courier* reported on three homeless black men who entered an old mill where anatomists had set up the body of another African American man for dissection. The men were so frightened that "they jumped through the open window, at least twenty feet from the ground below, and falling on their heads, of course escaped uninjured, and made off as fast as their legs could carry them."⁴²

Stories about dissection and black reaction to medical science solidified stereotypes of African Americans as helpless, deceitful, or child-like. Living African Americans appeared as comical characters alongside dead black bodies whose appearance on the dissecting table signified ownership by white physicians. A Georgia newspaper told of a medical student that took the index finger of an African American cadaver and passed it off to a saloon customer as a piece of sausage, much to the delight of the rest of the saloon.⁴³ Northern newspapers also used

⁴⁰ John Harley Warner, *Dissection: Photographs of a Rite of Passage in American Medicine: 1880-1930*. New York: Blast Books, 2009.

⁴¹ "Brief Mention," *The Daily True Delta*, January 20, 1861.

⁴² "A Ghastly Resurrection Story," *Charleston News and Courier*, February 11, 1878.

⁴³ "An Uninviting Plate of Sausage," *Georgia Weekly Telegraph and Georgia Journal & Messenger*, January 25, 1876.

humor when talking about dissection, but most comical dissection stories involving black bodies mentioned the South or allegedly came from below the Mason Dixon. When a New Orleans medical student supposedly saw the ghost of a dead African American man he was dissecting, the young man explained to it that he was “a poor student devoted to science, and did not suppose a dead colored gentleman cared particularly about having his head removed.”⁴⁴

The *Dallas Morning News* regaled its readers with a story of a Pennsylvania physician who made shoes from the skin of dissected black bodies, “insisting that the tanned hide of an African makes the most enduring and most pliable leather known to man.” ““Is the down-trodden African still beneath your feet?”” the newspaper reporter asked. The Northern doctor affirmed that he was, adding, “Were I a Southerner...I might be accused of being actuated by a race prejudice” but “I would use a white man’s skin for the same purpose if it were sufficiently thick.” The article then recounted all the items made from the skin of African Americans, reasserting nineteenth-century ideas of scientific differences between the skin of blacks and whites.⁴⁵

Scientific racism in the 1800s depended on the flawed but often discussed belief that African Americans differed anatomically from whites. Slavery, therefore, could be justified. African American resistance to diseases such as malaria preoccupied physicians in the nineteenth century and encouraged medical schools to study closely the workings of black bodies.⁴⁶ Physicians devoted to this racist understanding of science and medicine used dissection as proof of their claims and took that supposed proof to the public through newspapers. The *Daily*

⁴⁴ “This Doctor Saw A Ghost,” *The Daily Inter Ocean*, June 26, 1892.

⁴⁵ “Leather From Human Skin,” *Dallas Morning News*, October 27, 1887.

⁴⁶ Ronald L. Numbers and Todd Lee Savitt, *Science and Medicine in the Old South* (Baton Rouge: Louisiana State University Press, 1989), 328-338.

Missouri Republican reprinted an article from the *New Orleans Medical and Surgical Journal* about dissection and racial difference that argued, from an anatomical and physiological perspective, for the African American being “like a child...only fitted for a state of dependence and subordination.” The article went on to say that foreigners might have opinions on what was best for African Americans, but they were “without a knowledge of the physical differences between the Ethiopian and the Caucasian.”⁴⁷ One article reprinted over and over in the newspapers spoke of the differences in understandings of race science between Northerners and Southerners. The article alleged that while a Northern physician believed the African American skull was harder than the white man’s, a Southerner argued that it was a difference in skin texture that truly set them apart. The Southerner should know better, the article stated, as the Southern physician “could dissect for the Yankee a negro’s head with as much facility as a watchmaker will separate his own mechanism.”⁴⁸ Historian Deirdre Cooper Owens’s *Medical Bondage* which discusses how experimentation on black bodies reinforced notions that racial difference could be scientifically proven, shows how the work of doctors who focused on black bodies, such as J. Marion Sims, demonstrated that “the magnitude of their deeply held racist ideologies...was enough to obscure the findings of these medical men that black and white bodies were anatomically the same.”⁴⁹

It is no surprise that many of the physicians who founded the Southern medical schools had strong opinions about inequality between races. Samuel Henry Dickson, one of the founders of the Medical College of South Carolina, defended slavery in his *Remarks on Certain Topics*

⁴⁷ “Dr. Cartwright, of Louisiana,” *Daily Missouri Republican*, May 17, 1851.

⁴⁸ “Original Anecdote,” *Northern Whig*, August 9, 1811.

⁴⁹ Deirdre Cooper Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynecology* (Athens: University of Georgia Press, 2017), 111.

Connected with the General Subject of Slavery. His arguments that slavery should continue were reflective of the 1840s and a widespread belief that African Americans were unable to comprehend freedom and therefore not suited for anything beyond slave labor. He also believed that Africans were worse off in Africa than as slaves in the United States.⁵⁰ To prove that black people had no higher aim than servitude, he cited numerous “race scientists” who argued that African Americans by the 1800s had essentially devolved into lesser humans incapable of ever advancing to the level of whites.⁵¹ Dickson held to the same beliefs as Josiah Nott that a child born of a combination of white and black parents would be marked by “comparative infertility and the inferior average duration of his life.”⁵² Speaking fondly of his medical school time in Charleston, Sims said of Dickson, “I never heard such eloquence from a teacher’s desk.”⁵³

Physicians used newspapers as a medium through which they could acquire bodies by advertising their services to slaveholders, and gained experience in dissection of black bodies allowed them a niche area of medical discovery. Historians Stephen Kenny and Rana Hogarth argue that physicians opened slave hospitals to aid in their own professional development, and advertisements in newspapers in areas of the South most entangled in the slave trade expressed these interests. Physicians bought sick slaves, paid for their transportation to hospitals, and offered services at low cost to plantation masters. Newspaper discussions on dissection centered around medical colleges, and just as poorhouses and asylums supported medical colleges in the

⁵⁰ Samuel Henry Dickson, *Remarks on Certain Topics Connected with the General Subject of Slavery* (Charleston: Observer Office Press, 1845), 10-11.

⁵¹ *Ibid.*, 27.

⁵² *Ibid.*, 31.

⁵³ J. Marion Sims, *The Story of My Life* (New York: D. Appleton and Company, 1888), 117.

North, so the slave hospitals became the lifeblood of medical colleges in the South by offering opportunities for clinical experience and dissection. In 1833, Kentuckian Hector Green complained that he would have to send his slave in need of a surgery to either Cincinnati or Lexington “as the medical college” in his state was “not yet established.”⁵⁴

Northern newspapers invoked the imagery of dissection and the scientific knowledge gained through the process to criticize Southerners for dehumanizing blacks and breaking their bodies in slavery. The *New York Herald* published an article during the election of 1860 that condemned the callousness of slaveholders, for using dissection as a metaphor for how the sight of abused slaves could dull the sensibilities of Southerners: “Persons become accustomed to scenes of brutality till they witness them with indifference,” insisted the *Herald*, as with “a dissection at a medical college, where the president maintains the dignity of insensibility over a corpse, which he regards simply as the object of a lecture.”⁵⁵ Dissections of black bodies also provided insight into the physical horrors of slavery and the slave trade. The *Berkshire Reporter* pointed out that the dissection of slaves from slave ships proved they had died from suffocation and illness created by the conditions of travel.⁵⁶ A physician dissecting a slave in North Carolina showed he had perished from internal bleeding after a savage whipping, even though the master’s lash had never broken the skin. The article concluded by saying, “It does not appear that any punishment was inflicted on the inhuman perpetrator.”⁵⁷

African Americans’ expressed their views by petitioning city authorities for greater

⁵⁴ Hector Green Letter, December 1, 1833, Green Family Papers, Special Collections, Filson Library, Louisville, Kentucky.

⁵⁵ “The Presidential Contest,” *The New York Herald*, July 12, 1860.

⁵⁶ “Domestic Articles,” *The Berkshire Reporter*, February 28, 1807.

⁵⁷ “North Carolina Slavery,” *Independent American*, May 10, 1810.

protection of their cemeteries, attacking distrusted physicians, evading medical treatment, or challenging the unjust procurement of black cadavers. One of the most famous riots over a medical school's use of dead bodies was the "Doctors' Riot" in New York City in 1788. The riot broke out when locals caught students from Columbia College dissecting bodies they had stolen from local graveyards. The school defended their students' morbid endeavors by arguing that the students only used the bodies of the city's poor and the black residents, gathered from Negroes Burial Ground and the potter's field. Free blacks and slaves submitted a petition that the city intervene to stop the desecration of their cemeteries, but authorities took little action.⁵⁸

In July of 1885, a group of doctors arrived at the shanty of a local black man who was scheduled for a minor operation. A mob of the city's poor blacks quickly assembled to assault them with clubs and bricks. The doctors and the two policemen who arrived during the commotion fled for their lives.⁵⁹ Fear of dissection led to general fears of doctors and hospitals which could result in refusal of medical treatment. After someone shot a black man in the back in a street brawl, he escaped from the ambulance that came to his aid. The paper covering the incident argued that fear that he would die in the hospital and fall prey to the dissecting hands of the medical staff led the man to flee the ambulance.⁶⁰ After the hanging of a black man in Georgia, "some enraged negroes" attacked a physician because they "objected to his taking the body for dissecting purposes."⁶¹ An African American newspaper from Michigan known as

⁵⁸ David C. Humphrey, "Dissection and Discrimination: The Social Origins of Cadavers in America, 1760-1915," *Bulletin of the New York Academy of Medicine* 49, no. 9 (1973): 820-821.

⁵⁹ "Slap Doctors," *Washington Daily Yellowstone Journal*, July 10, 1885.

⁶⁰ "Pryor's Latest Scrape," *Kansas City Journal*, November 29, 1898.

⁶¹ "Launched into Eternity," *The Macon Telegraph*, November 22, 1891.

Plaindealer reported that authorities accused a black man of assaulting a white woman, shot him, and delivered his body for dissection to a medical school despite his family's pleas. The black citizens in the surrounding area hired a prominent black lawyer from Detroit to investigate the case and hold the police accountable for the manner of arrest and disposal of the body.⁶²

Despite the complications and obstacles, medical students did commonly use African American cadavers. When Josiah Tattnell arrived to study medicine in Savannah, Georgia, his internship under an established doctor in the city introduced him to the practice of body snatching. He was disturbed by the "digging up by the students of such negro subjects," but argued that "this invasion of the negro grave-yards was necessary in days when no other subjects could be obtained."⁶³ Tattnell's experience with medical training was not unique, and the *American Law Review* commented on the "wholesale robbery of a negro graveyard" by Philadelphia's Jefferson College. The writer lamented the state of medical knowledge in America that could not advance without more bodies but simultaneously condemned the body snatching.⁶⁴

Despite newspaper condemnation of body snatching or race relations, these narratives are complicated by the fact that newspapers also talked about African Americans participating in the traffic of dead bodies throughout the United States, frequently pointing to African Americans themselves as being the main facilitators. Blacks aided whites as resurrectionists, sometimes

⁶² "A Michigan Outrage," *Plaindealer*, July 8, 1892.

⁶³ Charles C. Jones, *The Life and Services of Commodore Josiah Tattnell* (Savannah: Morning News Steam Printing House, 1878), 7-8.

⁶⁴ Francis King Carey, "Disposition of the Body after Death," *American Law Review* 19, no. 2 (March-April 1885): 252-253.

receiving the clothing of the dead in payment.⁶⁵ Just as Northerners could blame Southerners for the frequent dissection of black bodies, Southerners could level accusations at Northerners for trying to acquire black bodies from the South.⁶⁶ One black man working as a resurrectionist in Washington, D.C. allegedly obtained bodies for Washington College from the potter's field for a sum of fifteen dollars per cadaver.⁶⁷ A Georgia newspaper reported that men from New York had arrived in the South asking how they could get fifty bodies for a medical school and whether they could "employ a negro to aid them in their work." Authorities implicated two black men who worked in the dissecting room of the School of Medicine of Maryland in the grave robberies of two wealthy women in Baltimore.⁶⁸ Newspapers also suggested that anatomists procured bodies by means more nefarious than grave robbery and trade. In Danville, Virginia, authorities arrested a William Dodson for hiring two black men to murder another black man for the sake of his body for dissection. Dodson was not a physician, just a man curious about anatomy who hoped to satiate his interest through the local black population.⁶⁹ After a black man from New Jersey murdered a black woman who owed him money, it was discovered that he had written to a medical student in Philadelphia asking if the student would purchase her body for dissection the week before the crime.⁷⁰

Even African American newspapers noted how blacks participated in the trade.

⁶⁵ "A Ghastly Resurrection Story," *Charleston News and Courier*, February 11, 1878.

⁶⁶ "Human Ghouls Visit the City to Secure a Few College 'Stiffs,'" *Columbus Enquirer-Sun*, May 31, 1887.

⁶⁷ "Body Snatching at Washington," *Times-Picayune*, January 18, 1893.

⁶⁸ "The Late Grave Robberies," *The Sun*, December 3, 1880.

⁶⁹ "A Rogue Defeated," *Salt Lake Herald*, April 26, 1883.

⁷⁰ "Dead or Alive: A Proposal to Sell a Live Woman for Dissecting Purposes," *Idaho Daily Statesman*, May 10, 1892.

Washington, D.C.'s *The Grit* reported that a "noted negro body snatcher" killed an African American family near Cincinnati and delivered their bodies to the Ohio Medical College for dissection.⁷¹ The black newspaper, *Huntsville Gazette*, testified that four African American grave robbers who funneled bodies to Philadelphia's Jefferson College required twenty-five policemen "to protect them from a mob of their own race."⁷²

African Americans sought power in refuting the mischaracterizations of themselves that newspapers perpetuated and the scientific racism popular in the nineteenth century. Britt Rusert's *Fugitive Science* argues that black writers, performers, and artists refuted white supremacy "not in the laboratory or the university, but in print, on stage, in the garden, church, parlor, and in other cultural spaces and productions" in a time before the professionalization of medicine and science.⁷³ Prominent African Americans like Benjamin Banneker and David Walker disproved assumptions about black intelligence and directly challenged dabblers in race science like Thomas Jefferson. African American artists corrected caricatures of black people in print culture that men like Josiah Nott claimed had scientific value even though they originated in racist and sensationalizing newspapers. Black writers like Hosea Easton in his 1837 *Treatise on the Intellectual Character, and Civil and Political Condition of the Colored People of the United States* noted that the production of pictures and stories in print which portrayed blacks as inhuman increased violence against blacks.

However, African American newspapers that mentioned dissection also tried to correct assumptions about blacks being inherently stupid or childish in their medical fears, educate

⁷¹ "South and West," *The Grit*, March 1, 1884.

⁷² "Personal and General," *Huntsville Gazette*, December 16, 1882.

⁷³ Rusert, *Fugitive Science*, 4.

blacks on the needs and importance of medical schools.⁷⁴ When the *Chicago Observer* printed an article about African Americans' dread of medical students, the editor of a black newspaper known as the *Washington Bee* reprinted the story but with an editorial comment saying that the article was a lie. "The colored people in this city are intelligent," it read, "and...possess too much sense to be frightened at any and everything."⁷⁵ African American newspapers even attempted to inform blacks of the usefulness of dissection. The Indianapolis *Freeman* counselled, "Post-mortem examinations will have a much greater value to science when people permit the body of a friend to be dissected whenever the physicians who treated that person in life desires it."⁷⁶ The New Orleans *Weekly Pelican* reprinted a detailed and unemotional explanation of the process of dissection to inform its readers.⁷⁷ African American newspapers also discussed dissection with humor, but the naïve actors the papers mocked were white instead of black. The *Plaindealer* told a story about an African American man by the name of Tom who sought vengeance on two white medical students who stole his friend's corpse for dissection. Tom ultimately took the place of the dead body and scared the students away, screaming.⁷⁸

Over the course of the nineteenth century, realization spread that the hallmarks of good medical education were clinical experience and opportunities for cadaver dissection which demanded more bodies for study, and as the introduction to this chapter highlights, medical schools in the South argued they were better *primarily* because of their access to black bodies.

⁷⁴ Derrick R. Spires's latest book, *The Practice of Citizenship*, looks at black print culture.

⁷⁵ "Frightened Negroes," *Washington Bee*, June 13, 1885.

⁷⁶ "About Vivisection," *Freeman*, July 19, 1890.

⁷⁷ "Students' 'Stiffs,'" *Weekly Pelican*, June 11, 1887.

⁷⁸ "In Place of A Corpse," *Plaindealer*, November 25, 1892.

Newspaper coverage of dissection also grew in the 1800s as interest in science and the number of proprietary medical schools increased. Southern medical schools could appear more attractive than Northern schools in the competition for students precisely because of their access to clinical material.⁷⁹ Advertisements for Southern medical schools claimed legitimacy by making such statements as, “The faculty can confidently assert that dissecting material is more abundant in New Orleans than elsewhere, and that Practical Anatomy will be thoroughly taught in this Institution” or that Charleston’s medical college maintained “a large and well supplied dissecting room.”⁸⁰

Newspapers were not the only sources boasting the clinical material of Southern schools as faculty in South Carolina and Arkansas mentioned it in catalogues and when writing about their schools. James Moultrie promoted the anatomical education that was available in Charleston and boasted it was more plentiful than in Paris. “Few cities can be compared with Charleston in the facilities offered for anatomical pursuits,” he declared.⁸¹ He further noted that compared to Paris, Charleston, “The supplies with us are, as ever, fully equal to the demand.”⁸² Students also received a lot of experience in dissections—“The dissections are conducted under the supervision of a demonstrator, and generally occupy the greater part of the student’s attention during his attendance for the first year of college,” Moultrie explained.⁸³ The *Arkansas Medical Monthly* also promoted clinical material and anatomical dissection. Some of the first

⁷⁹ Numbers and Savitt, *Science and Medicine in the Old South*, 220.

⁸⁰ “New Orleans School of Medicine,” *State Gazette*, August 29, 1857. “The Medical College,” *Charleston Courier*, November 7, 1859.

⁸¹ James Moultrie, *Memorial of the State of Medical Education in South Carolina* (Charleston, SC: Burges & Honour, 1836), 22.

⁸²Ibid.

⁸³Ibid.

advertisements for the school promised access to dissections and clinical experiences; “More than enough is afforded to satisfy the present demand; while the act passed by the state legislature legalizing dissection gives to this school a decided advantage of obtaining anatomical material.”⁸⁴

Arkansas’s medical school advertised not only that they had more cadavers but that their cadavers lasted longer than usual. William C. Dunaway, the “Demonstrator of Anatomy” at the school, published “Some Observations Upon the Preservation of Anatomical Material” in the *Medial Brief* in 1905. He promoted his radical ideas in embalming anatomical subjects that “revolutionized the interest in this study among students.”⁸⁵ Being able to embalm corpses allowed for greater access to anatomic material, since, as Dunaway noted, improper embalming methods made it impossible to complete dissections because of odor. At most medical schools, dissections could only occur in winter because indoor heat advanced decomposition. Because of his new methods, Dunaway claimed, the “dissection room is one of the most popular places, and the study of anatomy is one of the most interesting and pleasurable in the college course.”⁸⁶ He promised that with his method anatomic material could be available all year round, and perhaps for multiple years. The important thing was not to allow the anatomic material to dry out, so Vaseline was used to coat the cadaver. If cadavers could be preserved more effectively, the interest in anatomical study would increase: “Many practitioners in smaller towns who have specimens of interest, find themselves too busy to dissect at the time, and do not know how to

⁸⁴*Arkansas Medical Monthly* 1 (1880): 36.

⁸⁵ William C. Dunaway, “Some Observations Upon the Preservation of Anatomical Material,” *Medial Brief* 33 (1905), 400.

⁸⁶ *Ibid.*, 400.

preserve their material until a more convenient day,” he explained.⁸⁷

Recent discoveries suggest promoters and faculty did not make these boasts without cause. When archeologists excavated the basement of the medical school in Augusta, Georgia in 1989, they found over 9,000 human bones—two-thirds of which were African American.⁸⁸ Anatomists performed more autopsies and dissections on blacks than even poor whites in the South.⁸⁹ As Southern physicians dissected these people, white patients profited from black bodies as did the entire medical profession.

Kentucky, South Carolina, and Arkansas’s medical schools used their community connections to local hospitals, clinics, and almshouses to procure bodies, which often caused local tension. In Louisville, Kentucky, a citizen complained to the editor of his local newspaper that, since the Louisville Medical Institute was established, the bodies of patients at the Louisville Marine Hospital had been funneled to the school for dissection. The citizen worried, “I have no doubt but the dread of dissection not only keeps many away, who have claims on that charity, but fills the minds of the dying and irrecoverably sick, with agonizing apprehensions.” He called for stricter city regulation of the hospital to police the issue.⁹⁰ When Amzi Marten wrote a scathing pamphlet arguing that the LMI faculty were poorly managing the Louisville Marine Hospital to the detriment of the patients, he also exposed their use of the hospital for

⁸⁷ Ibid., 400.

⁸⁸ Robert L. Blakely and Judith M. Harrington, “Grave Consequences: The Opportunistic Procurement of Cadavers at the Medical College of Georgia,” in *Bones in the Basement: Postmortem Racism in Nineteenth-Century Medical Training*, ed. Robert L. Blakely and Judith M. Harrington (Washington: Smithsonian Institution Press 1997), 162-163.

⁸⁹ Savitt, *Medicine and Slavery*, 2002.

⁹⁰ “Louisville Marine Hospital,” *Louisville Morning Courier and American Democrat*, September 28, 1846.

cadavers. He argued that the medical school used the marine hospital especially for “its contribution to anatomical pursuits, and to the emolument of their Demonstrator of Anatomy. A very great majority of the bodies of the patients who die in the hospital, ultimately finds their way to the dissecting tables of the Institute, some of them passing directly from the one institution to the other, without even the forms of burial.” He also accused Dr. Drake of forbidding “the issuing of post-mortem notices, during his term of service,” in order that more bodies could be funneled to the school. According to Martin, local physicians were mad that the school was getting all the cadavers, but what was worse was the fact that information about how bodies were treated at the hospital “has come to the knowledge of that unfortunate class of our population whose necessities compel them to seek relief in such establishments, and has created a reluctance to go to the Hospital...and which fills the minds of the incurable and dying patients with anticipations more horrible to many, than death itself.” Martin was using a strategy to slander the medical faculty and ruin their community standing. He knew people were afraid of dissection, so he brought it to the public’s attention. “They know that I would oppose their reckless plunder of the dead-room of the Hospital, for the purpose of providing materials for dissection at the College,” he admitted.⁹¹

South Carolina’s medical school, in Charleston, was more forthright in admitting where they obtained their cadavers. A circular for the school advertised that its connection with the Marine Hospital and City Alms House not only provided “ample opportunities of observing medical and surgical practice” but also allowed “the diagnoses of the physicians confirmed or confuted, when opportunities occur, by post mortem examinations.” The school similarly

⁹¹ Amzi Martin, *Ingratitude and Oppression Exposed: Seven Beneficiaries of the City, and their Satalites, Destroying One of its Public Charities* (Louisville, 1845), 4-7.

proclaimed, “The advantages which our school affords for the study of anatomy are equal, to say the least, to those presented by any similar Institution in the United States.”⁹² In James Thatcher’s *American Modern Practice; Or, A Simple Method of Prevention and Cure*, published in 1826, advertisements promised students the “privilege of attending the practice of the Marine Hospital.”⁹³ Furthermore, it announced “arrangements for private dissection” and boasted that subjects were “obtained in abundance, and with great facility.”⁹⁴ Because of the school’s relationship with the Alms House, it was also likely to get dissection material from deceased poor persons there.⁹⁵ Many historians, including Stephen C. Kenny, Todd Savitt, Anne L. Grauer, Elizabeth M. McNamara, and David C. Humphrey have commented on the access that the Medical College of South Carolina exploited in the nineteenth century.⁹⁶

Because many of the free clinics were open only to poor white patients, some medical schools opened separate facilities for black patients. In Charleston, the Marine Hospital and Alms House were for whites only, but they opened an “Infirmary for Negroes” that abutted the

⁹² *Circular* (Charleston: Medical College of the State of South Carolina, 1830), 1-2.

⁹³ James Thatcher, *American Modern Practice: Or A Simple Cure of Disease* (Boston: Cotton & Barnard, 1826), 52.

⁹⁴ *Ibid.*, 52.

⁹⁵ Keith L. Eggener, “Old Folks, New South: Charleston’s William Enston Home,” *South Carolina Historical Magazine* 98 (1997): 251-280.

⁹⁶ See Stephen C. Kenny, “The Development of Medical Museums in the Antebellum American South: Slave Bodies in Networks of Anatomical Exchange,” *Bulletin of the History of Medicine* 87 (2013): 32-62, Todd L. Savitt, *Race and Medicine in Nineteenth- and Early-Twentieth- Century America* (Kent, OH: The Kent State Press, 2007), Savitt, “The Use of Blacks for Medical Experimentation and Demonstration in the Old South,” *Journal of Southern History* 48 (1982): 331-348, Anne L. Grauer and Elizabeth M. McNamara, “Bones in the Basement: Bioarcheology of Historic Remains in Nonmortuary Contexts” in Anne L. Grauer ed. *Bodies of Evidence: Reconstructing History Through Skeletal Analysis* (New York: Wiley-Liss, 1995), and David C. Humphrey, “Dissections and Discrimination: The Social Origins of Cadavers in America, 1760-1915,” *New York Academy of Medicine Bulletin* XLIX (1973): 819-827.

college in order to “exhibit such modifications of disease as are peculiar to the negro race.”⁹⁷ By opening separate hospitals for black people, Southern medical schools could corner the market for a growing interest in “Negro medicine” as well as remain competitive as businessmen in areas with a high concentration of African Americans. Experimenting on slave bodies in front of students and chronicling these cases in medical journals enabled Southern physicians to garner fame and respect from other physicians.⁹⁸ Were African Americans better off being experimented on by doctors like Sims or, having access to few other options, receiving no treatment at all for their ailments? With the growing number of studies addressing this question, it is clear that that answer is not the same in every situation.

Despite the sectional differences in how newspapers talked about dissection, using stories of dissection to try to control African American actions and political power through fear was a commonality in both the North and South. In 1884, a New Orleans newspaper reprinted a *Chicago Times* article that offered an explanation for why the Republican majority in Ohio was not larger. The article argued “There is nothing that the average Southern negro entertains such holy horror of as the dissecting table.” Blacks feared their murder and dissection by medical schools both North and South, and local newspapers in Cincinnati played on this fear by reprinting stories of murder and dissection to dissuade blacks from coming to the city for the

⁹⁷*Circular*, 2.

⁹⁸ Kenny, “A Dictate of Both Interest and Mercy” and Hogarth, *Medicalizing Blackness*. Todd Savitt has similarly shown that advertisements in Virginia and Kentucky tried to garner slave bodies for white physicians in *Race and Medicine in Nineteenth- and Early-Twentieth-Century America* (Kent, OH: Kent State University Press, 2007), 80-84. While Kenny and Savitt tend to see slave hospitals as sites of terror and abuse for African Americans, Hogarth suggests that slave hospitals in the South originated less in the desire to control and exploit the slave population than in a belief that black and white bodies needed segregated investigation and solutions for sickness because they were inherently medically different.

election. The article quoted the Cincinnati *Courier-Journal* which said the incoming African American men were “not wanted any more by the Republican managers than by the medical colleges, whose pickling vats, it is said, already contain the bodies of several ‘burked’ negroes who have fallen victims of the students’ hirelings, and are now ready for the dissecting table.” The article described the process of dissection in great detail and warned that several men were missing, but it also noted, “The ‘burkers’ are no doubt men of their own color, working ostensibly in the interests of Republican politicians, from whom they receive pay for each negro voter landed in the State, but in reality enticing their victims to death after having been paid for bringing them here.” The *Chicago Times* noted that “A more effective means of checking the movement of Kentucky negroes into Ohio could not have been devised.” Blacks supposedly panicked because of the *Courier-Journal*’s warnings. We cannot accurately know whether the newspapers affected lower voter turnout, but one tried to, and others continued a conversation on dissection and the uses of the fear it could produce within a context of understandings about sectionalism.⁹⁹

While fear of the gruesome or supernatural was a powerful, controlling force used on slaves by their masters, fear of murder and dissection by white doctors also continued after the war as a means to keep rural blacks from moving to urban areas where they might prosper. White landowners sometimes even dressed up as doctors to ride through black ghettos. It was in stories about villainous “night doctors” that old fascination with the supernatural fused with new interest in science after the Civil War.¹⁰⁰

⁹⁹ “Why the Republican Majority in Ohio Was Not Larger,” *The Daily Picayune*, October 18, 1884.

¹⁰⁰ Gladys-Marie Fry, *Night Riders in Black Folk History* (Knoxville: University of Tennessee Press, 1975), 179.

The story of dissection in the nineteenth century is a story of binaries—science vs religion, North vs South, and perhaps most interestingly, black vs white. These binaries did not soon disappear with time, however, and these newspapers link African American experiences in the distant past with much more recent atrocities committed in the name of medical education. Many of these newspaper stories might call to mind the modern experience of Henrietta Lacks, a black woman diagnosed with cervical cancer who died in 1951 and whose tumor provided material for breakthroughs in medical research on topics as varied as developing medicines for polio to cloning even though Lacks never authorized the harvesting of her cells. No example of the exploitation of black bodies for medical advancement is more famous in the United States than the Tuskegee Experiment, a forty-year-long study in which the federal government withheld the cure for syphilis from black, male patients in Alabama in order to observe the course of the disease. Nineteenth-century newspapers reveal that conceiving of the black cadaver as worth little more than medical material is a theme throughout the history of medicine in the United States and may help explain how the more modern use of African Americans' bodies without their consent could be accepted as necessary by some members of the medical community.

The linkages between dissection and race during this earlier period of American history seem clear. The need for bodies drove medical students, not just in the three schools in this study but more broadly, to find cadavers wherever they could and from sections of society where the practice would be largely ignored. Newspapers traced this story, and by talking about African American bodies in the South, they satiated growing fascination with science and dissection in ways that whites found less terrifying than humorous. Whites leveled sectional accusations about racial attitudes, delegitimized African American concerns about their vulnerability in society, and used black bodies to supplement knowledge of their own anatomy.

Blacks fought to protect their bodies through appeals to the law, use of force, and retaliations in their own newspaper accounts of dissection, thus guarding themselves when white physicians' pursuits of medical training demanded flesh from the least protected rungs of society. In a rapidly changing world undergoing technological revolutions that quickened the spread of information and the transportation of people, both dead and living, the human body remained a frontier of exploration but also exploitation. The situation divided communities over what science could demand of the public, who would satisfy that demand, and how society would respond to the cries of a group many considered expendable.

VI. Regulation of the Schools

Abraham Flexner had a fierce belief that medical schools in the United States were in an awful state. In 1910, he published *Medical Education in the United States and Canada*, now commonly referred to as the “Flexner Report,” in hopes of blowing the whistle. Flexner argued that medical schools were not only underfunded and ill regulated, they were also corrupt and exploitative of students who rarely received clinical experience. The Flexner Report was the culmination of a multi-year investigation backed by the Carnegie Foundation, and it was one of the first steps toward standardizing medical education. It was meant to draw the attention not only of school administrators, but also the public. As Henry Pritchett’s introduction to the report stated, “The attitude of the Foundation is that all colleges and universities, whether supported by taxation or by private endowment, are in truth public service corporations, and that the public is entitled to know the facts concerning their administration and development.”¹ With word circulating about cadaver dissection and the marginalization of local black communities, schools responded by initiating campaigns to retain students and regain prestige under scrutiny of the public. In this way, medical schools in Kentucky, South Carolina, and Arkansas responded to a report that became central to the medical professionalization crisis of the twentieth century.²

While this chapter looks at the significance of the Flexner Report and the problems that existed in medical education at the turn of the century, the schools’ response to the report will be

¹ Abraham Flexner, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation of Teaching* (Carnegie Foundation: New York, 1910), ix.

² Periodically, retrospectives and celebrations of the Flexner Report have appeared in medical literature, including Thomas P. Duffy and Howard Markel. Howard Markel, “Abraham Flexner and His Remarkable Report on Medical Education: A Century Later,” *JAMA* 9 (2010) 888-90 and Thomas P. Duffy, “The Flexner Report: 100 Years Later,” *Yale Journal of Biological Medicine* 84 (2011): 296-76. However, historians have been slow to address issues related to communities, body collection, and the intra-professional rivalries involved in these early medical schools.

explored in the conclusion of this dissertation. After the Flexner Report, the American Medical Association emerged as the premier professional regulating body, and licensing of physicians at the state level became a project of central importance. Licensed, university-educated physicians, eventually came to dominate medical practice and hold an exclusive monopoly on that practice by the middle of the twentieth century in the United States.³ Thus what might be called the reputational medicine that had seen so many slanders and disputes among doctors and faculty became regulated medicine.

Flexner was born in Louisville in 1866, and his ideas on race and education which began in childhood would later shape his investigation of medical schools. Though Abraham Flexner was a Kentuckian by birth, his family had immigrated to the United States in 1853. Growing up in Louisville, Flexner remembered many people he knew as “southern sympathizers,” and his autobiography recalled his early notice of differences in the social and economic conditions of black and white children.⁴ Flexner was especially interested in the poor state of education in the South as he grew up, and he noted that, in the schools of his childhood, the teachers were too old to be teaching and the schools were too poor to have necessary resources or books.⁵

In 1884, because of his brother’s income from selling pharmaceutical drugs in his store, Flexner was able to attend Johns Hopkins University. He had a positive experience at Johns Hopkins, and his experience there became his personal hallmark for quality when it came to medical schools.⁶ After making connections in Europe and America, Flexner found a research

³ Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1983).

⁴ Flexner, *Abraham Flexner: An Autobiography*, 3.

⁵ *Ibid.*, 17.

⁶ *Ibid.*, 37.

job at the Carnegie Institution in 1908 where he first gained fame by writing a survey called *The American College*.⁷ He then turned his attention specifically to medical schools and promised to share his findings with such professional organizations as the American Medical Association and the Association of American Medical Colleges.

In the report, Flexner argued that medicine's main problem in the United States was the overabundance of practitioners. Not only were there too many doctors, but many of them were not properly trained. The report blamed the excess number of practitioners on the numerous schools of medicine that drew students away from other careers. Because the main goal of medical schools was to make money for their investors, they mostly used a didactic mode of teaching that cost little money. Though there had been an increase in laboratory instruction in medical school curriculums, most schools were too poor or unwilling to invest the funds to improve. Medical schools of poor quality remained open because they served aspiring physicians who were also poor and could not afford a top tier school.

Flexner began his report with extensive contextualization of the history of medical training. The report situated the origins of American medical education in the Philadelphia medical circle, highly influenced and trained by European physicians. American medical education was rooted in anatomical demonstrations, and early teachers like William Shippen used these demonstrations to create interest and lure students.⁸ Flexner believed that the first medical school in the United States, the University of Pennsylvania, was also the best because it was a natural outgrowth of the university: "Our first medical school was thus soundly conceived as organically part of an institution of learning and intimately connected with a large public

⁷ Ibid., 70-71.

⁸ Flexner, *Medical Education in the United States*, 3.

hospital.”⁹ Flexner lamented that some schools, like Transylvania in Kentucky, also deteriorated over time: “The sound start of these early schools was not long maintained. Their scholarly ideas were soon compromised and then forgotten.”¹⁰ Prior to the nineteenth century, Flexner wrote, medical schools grew out of the university naturally: “Before that a college of medicine was a branch growing out of the living university trunk.”¹¹ It was from the natural growth, Flexner argued, that the quality could be maintained. He explicitly criticized Arkansas’s medical school in Little Rock as having a university affiliation in name only. “There is in every instance,” Flexner recommended, “a good reason why the university concerned should break off the connection.”¹²

In chronicling the declining quality in medical schools, Flexner stressed that there were too many of them. At the time he started his survey, there were 150 medical schools in the United States. The emphasis on laboratory teaching was fairly new, and most schools had a scarcity of medical specimens and anatomy instruction: “Occasional dissections in time supplied a skeleton—in whole or in part—and a box of odd bones.” Most of the teaching in medical schools during the nineteenth century was lecture based and not long in duration. “The schools were essentially private ventures, money making in spirit and object. A school that began in October,” he explained, “would graduate a class the next spring; it mattered not that the course of study was two or three years; immigration recruited a senior class at the start.”¹³ As an example,

⁹ *Ibid.*, 4.

¹⁰ *Ibid.*, 5.

¹¹ *Ibid.*, 5.

¹² *Ibid.*, 13.

¹³ *Ibid.*, 7.

Flexner pointed to the College of Physicians and Surgeons in Little Rock, Arkansas, which having only opened in 1906, produced a graduating class of seniors in 1907.

The faculty of medical schools stood much to gain from their affiliations. Chairs were sold to professors, who sometimes also had stock in the school. Flexner described the schemes by saying, “Income was simply divided among the lecturers, who reaped a rich harvest, besides, through the consultations which the loyalty of their former students threw into their hands.”¹⁴ Flexner admonished, “No applicant for instruction who could pay his fees or sign his note was turned down.”¹⁵ Yet their diploma from such schools, according to Flexner, gave graduates de facto license to practice medicine. In the apprentice system that existed before the nineteenth century, Flexner believed there was at least accountability among practitioners. Medical schools made it easier for ill-prepared students to slip through the cracks. “He no longer read his master’s books, submitted to his quizzing, or rode with him the countryside in the enjoyment of valuable beside opportunities,” Flexner explained.¹⁶ All the training that a young doctor got before beginning his practice was now to be procured within the medical school. The school was no longer a supplement; it was everything.

Flexner acknowledged the rivalries that poisoned the medical community as well, saying the fights were “ludicrously bitter. Still more acrid were—and occasionally are—the local animosities bound to arise in dividing or endeavoring to monopolize the spoils.” He also acknowledged that splits between medical schools were “rarely fatal: it was more likely to results

¹⁴ Ibid., 7.

¹⁵ Ibid., 7.

¹⁶ Ibid., 8.

in one more school.”¹⁷ In instances of interpersonal disputes between physicians, as with Daniel Drake, disrupters simply moved on to other schools.

Since the only cure for overproduction of doctors was to close schools, Flexner was sensitive to the fact that the South and rural areas would suffer most from lack of doctors. He estimated that an annual increase of 240 physicians would serve the need of physicians, allowing for one physician per 1500 persons. He noted that the year prior to his report, the South had 1144 new physicians, but only 78 of them had trained at one of the better schools, such as those in Philadelphia or Baltimore.¹⁸ He singled out Kentucky as “one of the largest producers of low-grade doctors in the entire Union.”¹⁹ Reiterating his point, he declared, “It appears, then, that the country needs fewer and better doctors; and that the way to get them better is to produce fewer.”²⁰

Flexner saw the problem of medical education as bigger than just the medical schools themselves. The students who entered them were poorly educated in general. Some medical schools required a year or less of previous schooling, and he lamented how hard it was to get states involved in requiring higher standards of admission. Medical schools in Kentucky and Illinois, for instance, had managed to resist reforms because the medical boards in those states did not want to “antagonize” them.²¹ Secondary schools in many of the Southern states were equally at fault for their poor preparation of students. Flexner suggested that all state universities

¹⁷ *Ibid.*, 7.

¹⁸ *Ibid.*, 17.

¹⁹ *Ibid.*, 17.

²⁰ *Ibid.*, 17.

²¹ *Ibid.*, 32.

in the South should have minimal standards of entrance, and in the case of medical schools, it should be two years of university study.²²

There were few things that Flexner railed about more than the dangers of professors who had lost touch with the advancement of science after they began to teach. Faculty needed to continue growing in their own medical and scientific understanding.

The one person for whom there is no place in the medical school, the university, or the college, is precisely he who has hitherto generally usurped the medical field,—the scientifically dead practitioner, whose knowledge has long since come to a standstill and whose lectures, composed when he first took his chair, like pebbles rolling in a brook get smoother and smoother as the stream of time washes over them.²³

Moreover, professors could afford to lecture students only a few hours a week because they were also busy as practitioners. Even then, standing in a huge amphitheater, the typical professor seemed content to drone on, “showing a bone between his finger-tips or eloquently describing an organ which no one but the prosector distinctly sees.”²⁴

Flexner pointed out that medical instruction could be divided into two parts: laboratory instruction and hospital observance. The laboratory sciences included anatomy, physiology, pharmacology, and pathology, while the other half focused on medicine, surgery, and obstetrics.²⁵ He thought through the problems of presenting topics like anatomy, whether it should be presented to students like a biology class or in the context of medical treatment.

²² *Ibid.*, 48.

²³ *Ibid.*, 57.

²⁴ *Ibid.*, 83-84.

²⁵ *Ibid.*, 57.

Anatomy, of all these subjects, was the one students should engage in during their time in medical school. It was “the oldest of the laboratory sciences” and it was more important than anything else a student could study.²⁶ Studying the body should occur at both the macro level and the microscopic level, and Flexner estimated that around one fifth of the time in medical school should be devoted to anatomy.²⁷ What concerned him was how much of that time was spent in the lecture hall versus individual experiences. Students needed to work equally between the hospital and the laboratory to succeed.

Flexner insisted that anatomy was taught conservatively. There were no courses on embryology, and other subjects, like osteology, were taught strictly through lectures, with no hands-on experience for the students.²⁸ Many of the schools did not have microscopes, and oftentimes students had only a single part of a body to analyze. Their education in anatomy was often provided by advanced students or alumni instead of professors. To make matters worse, dissection rooms were ill-kept and increased grim rumors about medical schools. “They contain tables, cadavers, and a vat; usually nothing more,” Flexner observed.²⁹ Furthermore, the treatment of the cadavers themselves was ghastly as “eight or ten inexperienced boys hack away at a cadaver until it is reduced to shreds.”³⁰ Some schools, like Barnes Medical College in St. Louis, prohibited dissection until the final year, as the younger students were prone to clumsily “hack and butcher.”³¹ The students spent too much time in lecturers. Flexner gave the example of the

²⁶ Ibid., 61.

²⁷ Ibid., 62.

²⁸ Ibid., 83.

²⁹ Ibid., 83.

³⁰ Ibid., 84.

³¹ Ibid., 88.

University of Louisville where 220 out of the total 450 hours of their medical training were spent in the lecture hall.³²

Medical schools needed access to bodies, and Flexner publicized this issue. He wrote that in many schools “the anatomy teaching goes on independent of dissecting.”³³ Some schools used surgeons to provide anatomical specimens, but many others simply did not have the equipment to teach anatomy properly. Flexner noted the Atlanta College of Physicians and Surgeons where students simply stole microscopes to make up for the lack of equipment to learn bacteriology. Schools from Georgia, Texas, and North Carolina do not offer students opportunities for “post-mortems.”³⁴ Students polled at these schools got access to a post-mortem perhaps twice during their six-year studentships, and as explored in the last chapter, this was also a problem at Transylvania. Schools tried to make due with specimens purchased “in the east.”³⁵ Flexner could see that the quality of education students received was largely in their own hands.

Flexner ended his report with suggestions for improvement. Mainly, he argued that medical schools needed to be under the control of universities and located in large cities. This would provide regulation for the school and allow students access to plenty of clinical material.³⁶ He noted that schools like the University of Arkansas, in Fayetteville, were disadvantaged because they were not in large enough cities and so would suffer problems if they tried to establish a medical school. Also, there should be no more than one school per town. Flexner

³² Ibid., 84.

³³ Ibid., 87.

³⁴ Ibid., 88.

³⁵ Ibid., 88.

³⁶ Ibid., 143.

offered as an example two medical schools that had formed in Little Rock and competed with each other.³⁷ Flexner also encouraged medical schools to focus on the local students as they were the most likely to enroll. Cities wanted medical schools to solidify their standing as up and coming metropolises. Flexner said the only thing Little Rock had going for it was that it had two railroad stops.³⁸ In his estimation, South Carolina, Arkansas, and Kentucky should have no medical schools at all.³⁹

Flexner also gave recommendations for educating women and the “negro” in his report. He was ambiguous and noncommittal about female medical education, and his comments on the issue amounted to less than two pages. Other than recommending further inclusion in co-educational schools, he had little else to say on the matter. “Now that women are freely admitted to the medical profession,” he mused, “it is clear that they show a decreasing inclination to enter it.”⁴⁰ He had more to say for future African American physicians. In his chapter “The Medical Education of the Negro,” Flexner noted that “the medical care of the negro race will never be wholly left to negro physicians,” but he expressed hope that that might one day be more common.⁴¹ He understood that black physicians taking ownership of black patient care would improve patient experiences, and he lamented that black patients generally saw poor white doctors who were ill-educated.

Flexner also believed that improving the health of the black population would directly improve the health of the white population. Communicable diseases like hookworm and

³⁷ Ibid., 120.

³⁸ Ibid., 145.

³⁹ Ibid., maps on pages 152-153.

⁴⁰ Ibid., 178.

⁴¹ Ibid., 180.

tuberculosis plagued both races confined in larger cities. “The negro must be educated not only for his sake, but for ours,” Flexner cautioned. “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.”⁴² Flexner saw the educated black doctor and nurse as the vanguard to improve communities through hygiene, but he worried about the quality of their schools, implying that “an essentially untrained negro wearing an M. D.” did more harm than good.⁴³ His attitude towards black medical education had a religious undertone as he envisioned the trained black physician as one possessing a “missionary spirit.”⁴⁴ Flexner lists seven medical schools that served aspiring black physicians but suggested that only Meharry in Nashville, Tennessee, and Howard, in Washington, D.C., should be saved. Howard had a wide donor base and a good hospital while Meharry had a strong alumni base and labs. If more money was funneled to these schools after the dissolution of the others, he believed they had a strong chance of survival.⁴⁵

⁴² Ibid., 180.

⁴³ Ibid., 180.

⁴⁴ Ibid., 180.

⁴⁵ Flexner’s bias against black medical schools has been examined in recent years. Louis W. Sullivan and Ilana Suez Mittman have pointed out that, just as Flexner suggested black physicians were only useful to treat black patients, current calls for diversity in healthcare continue to suggest that increasing the number of black medical professionals would help minority groups and underserved areas instead of arguing for diversity for its own sake. In doing so, we have adopted Flexner’s “limited vision of the role of black physicians in America, thus marginalizing black students and their graduates.” Louis W. Sullivan and Ilana Suez Mittman, “The State of Diversity in the Health Professions a Century After Flexner,” *Academic Medicine* 85, no. 2 (February 2010): 246-253. Terry Laws argues that the higher entrance requirements Flexner prescribed for Meharry and Howard would have reduced student enrollment. The schools tried to combat this by writing to the Carnegie Foundation for more funding, but they refused to help. This trapped black medical schools in a cycle of subpar education standards, and the lack of medical schools and funding for them has led to continuing underrepresentation of black people in medicine. Terry Laws, “How Should We Respond to Racist Legacies in Health Professions Education Originating in the Flexner Report,” *AMA Journal of Ethics* 23, no. 3 (March 2021): 271-275.

The bulk of the report offered a synopsis of each medical school in each state, including data on their facilities, staffs, and students. In looking at Kentucky, which in 1909 had a population of 2,406,859, Flexner found that 3,708 were physicians, a ratio of one physician per 649 citizens.⁴⁶ At the time of the survey, there were three schools operating in the state, less Transylvania, the state's original medical school, which had closed. Flexner's main interest, was the most successful one, the Medical Department of the University of Louisville. He thought admissions standards too low, with many students having a high school education or less. There were 600 students served by 90 staff members, 40 of which were professors. There were several chairs in medicine and surgery, but laboratory sciences were neglected. The tuition revenue was \$75,125 per year.⁴⁷ Flexner found that the laboratory facilities were not equal to the number of students at the school, but anatomy was, at least, supported by the city morgue. Clinicals took place in a hospital that served 50 patients, and the hospital usually had 30 patients and some surgical cases. Between 100 and 300 students observed cases there each week, but they saw no births or diseases. The medical school at the time was the largest in the country, but Flexner was disturbed by how little its hospital was utilized and the lack of diversity in clinical experience.⁴⁸

Flexner next visited the Southwestern Homeopathic Medical College in Kentucky. The school was founded in 1892 and had the same requirements for admission as the University of Louisville. It served thirteen students with a faculty of 27, which included 12 professors.⁴⁹ Flexner was very hard on the school, noting that the lab facilities were in terrible shape: "There

⁴⁶ Flexner, *Medical Education in the United States*, 229.

⁴⁷ *Ibid.*, 229.

⁴⁸ *Ibid.*, 229.

⁴⁹ *Ibid.*, 230.

is no outfit worth speaking of in any department; the building is wretchedly dirty, especially the room said to be used for anatomy. There is nothing to indicate recent dissecting.”⁵⁰ Interestingly, the school had access to clinical cases as they were promised a fifth of the hospital patients “for demonstrative purpose.”⁵¹ They operated on a budget of \$1100 per year.

Last was the Louisville National Medical College that served the black population of Kentucky.⁵² Flexner noted that the school was affiliated with the “colored State University,” and the admission requirements barely required some high school experience. The school had a student body of forty students and a staff of 23, 17 of whom were professors. Flexner spent little time describing the school, noting that the labs were “nominal” and there was a modestly sized hospital for eight patients run by the school. The school grossed approximately \$2500 annually.⁵³

Flexner was direct with his conclusions. He wanted the Southwestern Homeopathic Medical College closed because it was “without merit.” The graduates deserved “no recognition whatsoever” because the school lacked “the most elementary teaching facilities.”⁵⁴ He noted that, historically, Louisville’s many medical schools did not attract the best students. He described the city as a place where “crude boys thronged from the plantations,” which the schools offering “little beyond didactic teaching.”⁵⁵ Flexner interpreted high numbers of students to mean the schools were too easy.

⁵⁰ Ibid., 230.

⁵¹ Ibid., 230.

⁵² Ibid., 230. Flexner used the term “Louisville National Medical College (Colored).”

⁵³ Ibid., 230.

⁵⁴ Ibid., 230.

⁵⁵ Ibid., 230.

Flexner did not paint an optimistic future for medical schools in Kentucky, primarily because they could not provide enough resources or stick to rigorous academic standards. Even the University of Kentucky ranked low, a circumstance he blamed on its president, Henry S. Barker, a man he described as not a true academic but a politician.⁵⁶ Flexner contended that even using the term university to describe institutions like the University of Louisville was misleading:

We have indeed progressed too far in our social and educational development to use the word “university” for an enterprise of this kind. Classes in literature, languages, and elementary science may indeed be organized by volunteer teachers, in hours left open by their regular engagement, or by instructors supported from year to year by subscription; they may discharge a highly useful office in any community, but they ought to be called by their right name. An academic department of a university they are not, why should they not be described as a people’s institute, or by some other designation calculated to indicate their actual character? The loose use of the words “college” and “university” prolongs educational chaos; it hinders the apprehension of genuine and fundamental educational distinctions. Assuredly, an institute of the type described cannot dominate or transform a hitherto independent group of medical schools.⁵⁷

Of the three Southern states examined in this study, Flexner criticized Kentucky the most.

In February of 1909, Flexner visited the single medical school in South Carolina, the Medical College of the State of South Carolina, located in Charleston. The school had opened in 1828 and had 213 students at the time of Flexner’s visit. The state of South Carolina had a

⁵⁶ Ibid., 231.

⁵⁷ Ibid., 231.

population of around 1,510,566, and Flexner estimated that its 1141 physicians gave the state around one doctor per 1324 people.⁵⁸ He described the school's entrance requirements as "nominal." The faculty consisted of 34 people, 11 of whom were professors. Despite this number of staff, the college had no one teaching full time. By Flexner's estimation, the school had about \$19, 447 on hand for improvements.⁵⁹

The facilities for chemistry, anatomy, and the teaching of pharmacy were passable, but the conditions for teaching dissection were very poor.⁶⁰ There was one lab but the students had few additional resources: "There is no museum, except old papier-mâché and wax models, no library, except some antiquated publications," Flexner reported.⁶¹ Students only had access to clinical observations at the local Roper Hospital, a facility a mile away from the school, with its 200 patients. As previously mentioned, tensions were high between the hospital and the school, and Flexner noted that graduates often refused to serve as interns at the facility. Students again had no experience with obstetrics.⁶²

Neither did Arkansas impress Flexner. Arkansas had an overall population of 1,476,582, and there were about 2,555 physicians in the state. The ratio of physician to citizen was 1 for every 582, and the two schools serving the state continued to pump out more doctors. Both medical schools were located in Little Rock which had a population of 44, 931.

The Medical Department at the University of Arkansas was the original school founded in 1879. The requirements for study were deemed "nominal" by Flexner. The school had 179

⁵⁸ Ibid., 301.

⁵⁹ Ibid., 301.

⁶⁰ Ibid., 301.

⁶¹ Ibid., 301.

⁶² Ibid., 301.

students, 81% of them were native Arkansans.⁶³ There were 35 members of the staff and 18 of them were professors. The revenue generated from tuition was estimated by Flexner to be \$14,100 per year. Flexner was appalled by the laboratories. He noted that the school had been around for thirty years prior to having labs, and the labs it had at the time of visit were only for dissection and inorganic chemistry.⁶⁴ The labs and facilities were in disrepair, and the school had no museum and few books. The clinical areas were also weak. A partnership with the City Hospital, which could accommodate only thirty patients, had an “amphitheater” where the patients were brought from their beds for the students to observe. There was also a small dispensary, but the students did no rounds and saw no contagious diseases or obstetrics. “Of post-mortems,” Flexner lamented, there was “no mention.”⁶⁵

The second medical school in Arkansas was the College of Physicians and Surgeons, which had only opened in 1906. There were 81 students, around 59% of them from Arkansas. The staff included 34 people of whom 25 were professors. The tuition revenue that the school generated was \$6,450. Its two laboratories were in rough shape, and both were managed by a physician who also worked at the County Hospital. The dissecting room was labeled “wretched” by Flexner. The only patients students observed were wheeled over from the nearby County Hospital, which allowed them no experience with child deliveries, diseases, and post-mortems.⁶⁶

Flexner concluded that Arkansas was producing more than three times the number of doctors the state needed. Neither of the two schools, he declared, had “a single redeeming

⁶³ Ibid., 188.

⁶⁴ Ibid., 187.

⁶⁵ Ibid., 187-188.

⁶⁶ Ibid., 188.

feature.”⁶⁷ He was in disbelief that the University of Arkansas would allow its good name to be associated with its school. Flexner advocated moving the University of Arkansas from Fayetteville to Little Rock in order to support one respectable medical school in place of two poor ones.

In 1912, the *Yorkville Enquirer* ran a story entitled “Fake Medical Schools” which quoted Henry Pritchett of the Carnegie Foundation. “Scandals in medical education exist in America alone,” he insisted. “In no foreign country is a medical school to be found whose students do not learn anatomy in the dissection room and disease by the study of sick people. It has remained for the United States and Canada to confer annual the degree of doctor of medicine on and to admit to practice hundreds who have learned anatomy from quiz-compendes, and whose acquaintance with disease is derived not from the study of the sick, but from the study of textbooks.”⁶⁸ These were sobering words for a public that already had reason to distrust medical schools and doctors.

Though the Flexner report was critical of the medical profession generally, some physicians and communities saw it as a very positive development. A professor at the University of Louisville, Curran Pope was interested in reforming medicine in Kentucky. Pope published an editorial on the value of the Flexner report in the *Kentucky Medical Journal*, defending it against others in the medical profession who were offended by Flexner’s findings. He described the issues raised by Flexner as “very hard things concerning the medical fraternity” but necessary to build community trust in medicine.⁶⁹

⁶⁷ *Ibid.*, 188.

⁶⁸ “Fake Medical Schools,” *Yorkville Enquirer*, July 5 1912.

⁶⁹ Curran Pope, “Scientific Editorials: Commercialism: A Rudge Awakening,” *Kentucky Medical Journal* 10 (1912): 373-374.

Interest in bodily dissection and writing about dissection in medical schools increased after the publication of the Flexner report. In Kentucky, *The Blue-Grass Blade* ran an article called “Scientific Experiments Upon Criminals” that promoted the use of dissection as instruction. “While many well-minded, yet sentimental people have uttered a vehement protest against vivisection and dissection as a means of arriving at the cause and effect, as well as the cure, of many of the ills that affect humanity,” the publication mused, “it must be candidly admitted that much valuable scientific knowledge has been acquired under such experiments as these.”⁷⁰ The article praised efforts by the Kentucky legislature to “take such steps as will legalize a series of scientific experiments upon the bodies and persons of criminals condemned to die, provided it is done with the consent of the criminal.” The *Blade* praised this as “a decided step forward in scientific experimentation.”⁷¹

South Carolina also took a more favorable approach to dissection. The *Keowee Courier* reflected the general tone in an article entitled “In the Interest of Science: Two Hundred Physicians Agree to Give Bodies to Science.” It praised the rationale of doctors who donated their bodies for the sake of medicine: “By allowing their bodies to be dissected after death, the physicians believe, they will show the public in a practical way that autopsies, to which many have expressed opposition, are really great aids to science. Especially are autopsies valuable, so the physicians believe, in studying diseases of mysterious and obscure origin.” It noted that “100 circular letters” were sent out to families of deceased patients asking them to consent to dissection.⁷²

⁷⁰ “Scientific Experiments Upon Criminals,” *Blue-Grass Blade*, December 13, 1908.

⁷¹ *Ibid.*

⁷² “In the Interest of Science: Two Hundred Physicians Agree to Give Bodies to Science,” *Keowee Courier*. October 16, 1912.

However, concerns about dissection did not wholly vanish. As Flexner's description of the abuse of cadavers circulated, South Carolina newspapers published stories that linked mysterious and strange deaths with medical school treatment. *The Watchmen and Southron* published an article with the title "Does Electrocutation Kill?: Scientists Say it Only Stuns Victims—Post-Electrocutation Operation Responsible for the Death of Those Who Go the Electric Chair." The article questioned whether a wife-murderer by the name of Samuel N. Hyde died from his electrocution in Columbia, South Carolina or from the dissection that followed. The article reported that a "noted scientific man" (a faculty member at a medical school) gave the opinion that electrocution "only renders the victim unconscious and that the real death comes after the body goes upon the operation table."⁷³ He also waxed philosophical on the nature of electricity and the body, and how little was known about the relationship. He observed how strange it was that the United States was the only country in the world that used electricity to kill criminals. He then related strange cases where people seemed to wake up after being electrocuted, even while on the dissecting table. Another physician was quoted as stating, "Many of the men who have been pronounced electrocuted in New York State have been placed upon the dissecting table conscious of what was going on and what was about to take place."⁷⁴ The reporter ended by saying, "This hardly seems like capital punishment: it is more like human vivisection—yes, torture in its most refined form. Is this the best form of capital punishment we can devise?"⁷⁵

⁷³ "Does Electrocutation Kill?: Scientists Say it Only Stuns Victims—Post-Electrocutation Operation Responsible for the Death of Those Who Go the Electric Chair," *The Watchman and Southron*, January 15, 1913.

⁷⁴ Ibid.

⁷⁵ Ibid.

Arkansas also voiced frustration over what was perceived as poor medical education. *The Prescott Daily News* in 1915 covered the problems that the American Medical Association found with medical education in America. Running the eye-catching title, “Prospective Medical Students and Low-Grade Medical Colleges,” the article sought to warn anyone interested in becoming a physician in the United States. “Statistics recently published by *The Journal of the American Medical Association* show,” the paper pointed out, “that in from ten to thirty-three states, the diplomas issued by medical schools are not recognized, and that in these states the graduates of these thirty-five schools are not admitted to the examinations for licenses to practice medicine.” It was in the students’ best interest, the article warned, to research these schools and their standing within the medical community. It continued, “Hundreds of students, in fact, have enrolled in low-grade medical colleges, have spent large sums of money, and have graduated before they have learned not only that they have not received a training in modern medicine, but also that they have received diplomas which are worthless in a large number of states.” Newspapers throughout the 1910s and 1920 argued that the medical school attached to the University of Arkansas upheld the highest standards.⁷⁶

The Flexner Report generated focused criticism about the lack of equipment and support that had plagued these schools since they were founded. In many cases, the schools’ communities and local government stepped up to respond to the flaws in the report and saw the improvement of the schools as a point of community pride. Anxieties about dissection as well as lack of opportunities for minorities did not magically dissipate, but the schools in Kentucky, South Carolina, and Arkansas survived and adapted despite the denunciations they had received

⁷⁶ “Prospective Medical Students and Low-Grade Medical Colleges,” *The Prescott Daily News*, May, 24 1915.

in the report. At least for white, male medical students at white medical schools, the report paved the way for more transparency and community-based medical education. As in the wider historical narrative, reform paved the way for the broader Civil Rights explored in the final chapter of this study.

VII. Changing Missions and Communities

This study has argued that doctors in the South were their own biggest obstacles to success. Southern doctors tried to carve out a place for their medical schools and gather the support of the community and their peers. In order to succeed, they had to make an argument to potential students that their school taught the latest scientific ideas, were superior to their rivals, and had access to a consistent supply of dissection and clinical material. However, the competition for the best reputation in Southern medicine often involved denouncing rivals, which led to intra-school fights and even duels between physicians. The continuing competition among physicians weakened the medical community until publication of the Flexner Report. Flexner helped close rivalries between schools and rallied the profession around university affiliated medical schools. Yet, even then, damage done to the profession over access to dissection material, which played on the racialized nature of the South, left a problem of trust between the mostly white professional medical education system and African American communities. That lack of trust would be a source of struggle for black people trying to access medical services in the South in the twentieth century, often at these same medical schools. Today, the mission statements of the medical schools examined in this study clearly attempt to rebuild the trust of the African American community that they now envision themselves serving.

So how did medical schools in Kentucky, South Carolina, and Arkansas respond to the reforms recommended by Flexner? They continued to build trust and good relationships with their white communities, the results being that the schools crafted reputations in those communities as useful and necessary service-oriented institutions. Yet, these schools still had to undergo drastic changes to survive Flexner's criticisms, and that could not have been possible without an influx of money provided by state involvement and investment.

Likely encouraged by the state medical society, the Kentucky legislature eventually responded to the Flexner Report, its opinion subsequently published in the *Kentucky Medical Journal*. The legislature seemed particularly concerned with strengthening admission requirements at its schools.¹ In future, candidates for admission would have to present the dean with acceptable qualifications or submit to an examination. Acceptable qualifications included a college degree, a high school degree, or teaching credentials.² The enforcement of such admissions standards was emphasized as extremely important if medical education at the University of Louisville was to gain prominence. The Kentucky medical society, endorsing the legislature's findings, described the university as "an ally," particularly because most of its members were graduates. "With our support," the society claimed, "we can place it in the front rank amongst medical colleges."³

Following the failure of Kentucky's first medical school, Transylvania University,⁴ the University of Louisville Medical Institute enjoyed preeminent status among Kentucky schools from its founding in 1846 until the later part of the twentieth century, but the competition became fierce.⁵ In 1910, the *American Medical Association Bulletin* published a negative report by a Dr. C. Z. Aud that was clearly influenced by Flexner's findings. He highlighted the combination of the competing medical schools in the state and hoped that combining all schools

¹ *Kentucky Medical Journal* 8 (1910): 1851.

² *Ibid.*, 1852.

³ *Ibid.*, 1852.

⁴ John Dean Wright, *Transylvania: Tudor to the West* (Lexington: University of Kentucky Press, 1980) and William E. Ellis, *History of Education in Kentucky* (Lexington: University of Kentucky Press, 2011).

⁵ See <https://surgery.med.uky.edu/im-history>; the website was based on the article, Dorothy Clark and Gordon L. Hyde, "A Brief History of the University of Kentucky Department of Surgery," *Journal of the Kentucky Medical Association* 82 (1984): 343-347.

in Kentucky into the Medical Department of the University of Louisville would resolve all issues. “The work of combining these schools was a very difficult proposition,” Aud lamented, “but we succeeded.”⁶

It had competition from competing medical schools in Louisville with names that sounded vaguely associated with the university such as the “Louisville Medical College” in the Reconstruction period.⁷ All existed in hopes of securing state funding. Competing propriety schools attacked each other, as did the Medical Department of the University of Louisville through its own publications.⁸ Ultimately, in 1908, the University of Louisville took over the Louisville Medical College. None the less, while the state government of Kentucky had passed legislation that provided for the inspection of food and drugs as well as allowing public health officials to vaccinate citizens, the medical education problems had not been resolved.

The Medical Department of the University of Louisville came under the direction of James M. Bodine who was praised in the pages of the *Lancet-Clinic* in 1911 for having “his signature upon more doctors’ diplomas than any other college head in the United States.”⁹ In addition to being an accomplished anatomist, Bodine taught Simon Flexner, the brother of Abraham Flexner, who eventually went to work for the Rockefeller Institute. Bodine also worked with the Association of American Colleges. Kentucky survived the 1920s and 1930s despite damaged and weathered facilities, and in the World War II era they received the state and

⁶ *The American Medical Association Bulletin* 4-6 (1910): 148.

⁷ Dwayne D. Cox and William J. Morison, *University of Louisville* (Lexington: University of Kentucky Press, 2000), 17, 31-38, and 59-63.

⁸ Hampden C. Lawson, “The Early Medical Schools of Kentucky,” *Bulletin of the History of Medicine* 24 (1950): 168-175.

⁹ *Lancet-Clinic* 113 (1915): 163.

federal support needed to remain open. However, competition in the state and struggles for capital remained a source of stress.

As for South Carolina, several historians have pointed out that the state's medical school did not receive any state funding from 1824 to 1913 and thereby acted as a private institution.¹⁰ Money made the schools, and physician-scholars like W. Curtis Worthington, Jr. have argued convincingly that for the state of South Carolina to purchase the medical school and properly fund it was the only way it could have survived the criticisms leveled by Flexner.¹¹ The purchase was not without controversy, however, as there was opposition for the school going public in both the state government and from within the faculty. There was even a suggestion that the University of South Carolina should open a new competing medical school that might drive the other out.¹² It was ultimately the physicians of the state advocating for the improvement of the physical facilities of the current school that made the difference.¹³

South Carolina purchased the institution in 1913. This era is known pejoratively to local historians as "Robert Wilson's War," named after Dean Robert Wilson who fought for the school to be taken over by the state. Wilson hoped that with state funding the institution could be

¹⁰ See Joseph Ioor Waring, *A History of Medicine in South Carolina 1670-1825* (Charleston: South Carolina Medical Association, 1964), *A History of Medicine in South Carolina, A History of Medicine in South Carolina 1825-1900* (Charleston, South Carolina Medical Society, 1964), *A History of Medicine in South Carolina: 1900-1970* (Charleston: South Carolina Medical Association, 1964), and Jane McCutchen Brown, "Medical University of South Carolina" in *South Carolina Encyclopedia*: <https://www.scencyclopedia.org/sce/entries/medical-university-of-south-carolina/>

¹¹ W. Curtis Worthington, Jr., "A Study in Post-Flexner Survival: The Medical College of the State of South Carolina, 1913," *Journal of the American Medical Association* 266 (1991): 981-984.

¹² Ibid.

¹³ Ibid.

brought up to Flexner's standards and survive.¹⁴ Old worries surfaced, however, that with state control, the institution might be moved from Charleston to Columbia.¹⁵ That did not happen, and the increase in state funding was further bolstered by a partnership with the community that raised funds for a new building in Charleston.¹⁶ In 1915, South Carolina's governor praised the school in his farewell address for making so many changes.¹⁷ *The Journal of the American Medical Association* in 1919 promoted the fact that faculty were donating to the Medical Department of the University of Louisville in an effort to give the school resources it needed.¹⁸ It received a shocking \$5,000 from one of the faculty.

Schools that showed a willingness to change were rewarded by their communities with large appropriations from their respective states. In South Carolina, the Medical College received \$96,067 from the state in 1920.¹⁹ In 1922, the school had a recommended appropriation of \$84,955 but received more than \$100,117.²⁰ Prior to these large appropriations, in 1911, the state government had also seen fit to propose \$10,000 every year for scholarships.²¹ The 1950s and 60s saw even higher investment from the state to improve the school, and the college received their own hospital in 1955.

In 1969, the Medical College of South Carolina changed its name to the Medical University of South Carolina. For a long time the Charleston school had enjoyed a monopoly as

¹⁴ Ibid.

¹⁵ Recall the desires of Thomas Cooper to move the school to Columbia and Ibid.

¹⁶ Ibid.

¹⁷ *The Anderson Daily Intelligencer*, January 13, 1915.

¹⁸ *The Journal of the American Medical Association* 73 (1919): 514.

¹⁹ *The County Record*, March 11, 1920.

²⁰ *The Watchman and Southron*, February 18, 1922.

²¹ *Yorkville Enquirer*, January 24, 1911.

the only medical school in the state, but in 1977, the University of South Carolina, in Columbia, finally achieved the hopes of Thomas Cooper and secured funding for its own medical school. The medical school at the University of South Carolina opened with a partnership with the Veterans Administration.²² Another medical school opened its doors in upcountry South Carolina, with the University of South Carolina School of Medicine at Greenville opening an Osteopathic Medical School. Both institutions opened because of an argument made before the state that there was a shortage of doctors in South Carolina. These schools continue to promote their place and need in South Carolina medicine based on the scarcity of providers.²³

The Flexner Report certainly spurred Arkansas's state government to action. The *Forrest City Times*, a newspaper with the tag line "Fear God, Tell the Truth, and Make Money," ran a story saying that the "State Hospital is Planned: University Medical Board Will Elect Big Institution for Arkansas." The article promoted the excitement over the new "charitable" hospital. Money to fund the school would be raised by selling school lands that the University of Arkansas already owned. Most importantly, the hospital would "be a part of the medical school" and welcome patients from "all over the state."²⁴ *The Log Cabin Democrat* on September 23, 1915, also trumpeted the "Free Hospital" being planned in Little Rock. It described the building as having three levels and being attached to the medical school, following the recommendations

²² Henry H. Lesesne, *A History of the University of South Carolina, 1940-2000* (Columbia: University of South Carolina Press, 2001), 292-294.

²³ For an institutional history of the University of South Carolina School of Medicine see Donald Saunders, *To Improve the Health of the People: An Insider's View of the Campaign for the University of South Carolina School of Medicine* (North Charleston: Book Surge, 2005). Also see the public engagement of the school on Facebook. Also note that the University of South Carolina School of Medicine is located in Columbia, while the Medical University of South Carolina (formerly the Medical College of South Carolina) is located in Charleston.

²⁴ "State Hospital is Planned: University Medical Board Will Elect Big Institution for Arkansas," *The Forrest City Times*, November 28, 1913.

of Flexner.²⁵ “The hospital, which is being built with \$20,000 and interest in the Dr. Isaac Folsom free clinic fund,” the newspaper glowed, “will be modern in every respect, and according to Dr. Smith will be thrown open for the free treatment of patients all over Arkansas.” By 1917, *The Prescott Daily News* excitedly announced the hospital’s opening. It praised the state legislature for so generously equipping the hospital and emphasized how the state would bolster the medical school. The new facility, which the article referred to as the “State General Hospital,” would be located “in the building formerly occupied by the Medical School.” To cover remaining costs the state legislature proposed that the governor should “issue an emergency proclamation for \$30,000 to be used in equipping the old building.”²⁶

Arkansans endorsed more rigorous standards in the medical school and more training opportunities for physicians. *The Newport Daily Independent* reported that 37 students graduated from the medical school in 1914, but future graduates would face higher requirements for admittance, indicating the effect of Flexner’s recommendation about stricter admissions. All students would have to pass “a satisfactory scholastic examination before entering the medical school.” In recounting the history of the previous admissions situation, the paper informed readers, “The old state law permitted any one to enter the medical school, no matter how little education he had. This class was already matriculated in the old medical school before it was taken over by the state and new rules put in force. The present under classes have all qualified under the new law.”²⁷ The new entrance requirements included a written examination, “14 high

²⁵ “Free Hospital Being Planned,” *The Log Cabin Democrat*, September 23, 1915.

²⁶ *The Prescott Daily News*, August 31, 1917.

²⁷ *Newport Daily Independent*, May 12, 1914.

school units,” and at least one year of college.²⁸ *The Prescott Daily News* promoted additional training opportunities for physicians in Arkansas in 1914. It endorsed the training, which would be held at Arkansas’s medical school, as “the first free post graduate medical course in the United States.” The course would last thirty days, and “a great number of physicians over the state” reportedly hoped “to get from the Arkansas school something they can cannot secure from other medical universities.”²⁹

Even when not mentioning the Flexner Report by name, commentators sensed the change taking place in medical education. *The Sentinel-Record* out of Hot Springs, Arkansas ran an article about the value of there being “Fewer Medical Schools.” The article noted that, not only were there fewer medical schools than in the past, but there had also been 1,200 fewer people studying medicine over the past year—and “a decrease of 500 in the number of medical graduates.” The declining numbers of medical graduates seemed a positive development and reflected higher standards of medical education, “The reduction in the number of medical schools is part of a steady movement for improved medical education that has been going on for the past 8 and 9 years,” the report suggested. It also noted that the work of “various State medical societies, and other agencies” had “aroused public opinion,” the result being that around 79 medical schools had closed down. States like Kentucky were also praised for better regulation of medical education.³⁰

Like the others, Arkansas’s medical school needed more money. A mere nine years after the Flexner Report was published, the school was reduced to offering only the first and second

²⁸ *The Prescott Daily News*, September 16, 1915.

²⁹ *The Prescott Daily News*, May 12, 1914.

³⁰ “Fewer Medical Schools,” *The Sentinel-Record*, December 21, 1913.

years of the medical curriculum, forcing students to transfer to other schools to complete their degree.³¹ Though there were large allocations from the state after the Flexner Report, some in the state legislature wanted to eliminate the school altogether. Ultimately, it was the support of the community and particularly the partnership with private hospitals in Little Rock that allowed the university to scrape by until enrollment increased and its reputation improved.³² In 1921, legislative Act. No 571 gave the school \$35,000 for paying professors and general maintenance.³³

Arkansas did not receive a lot of praise from the American Medical Association. In 1920, the *Journal of the American Medical Association* tore the state's medical community apart.³⁴ "Arkansas evidently still elects to be the ground for quacks, charlatans and half-baked medical practitioners coming from schools not recognized in the majority of states," it said bluntly. It noted that there were several regulatory boards in Arkansas that dealt with different types of practitioners including a "homeopathic board, an electric board, an osteopathic board, a chiropractic board and an optometry board."³⁵ The editor cautioned that "any other cult seeking recognition could doubtless easily secure it in the wide open and generous state of Arkansas." The editor also mentioned that it was easy for students to enroll at the school and become certified in Arkansas because of the large number of boards. "How long are the people of

³¹ David Baird, *Medical Education in Arkansas, 1879-1978* (Memphis: Memphis State Press, 1979), 67-225.

³² *Ibid.*

³³ *The Home News*, June 17, 1921.

³⁴ "Current Comment," *Journal of the American Medical Association* 74 (1920): 465-466; the citation was found in Baird, *Medical Education in Arkansas*.

³⁵ *Ibid.*, 465.

Arkansas going to stand for such flimsy protection against ignorance and incompetence,” the journal asked. “Do they appreciate the fact that they themselves are and will be the sufferers?”³⁶

The school also continued to have difficulty keeping anatomical specimens well after other schools had improved in that area. Students and faculty have testified to historians about the state of anatomical education during the pre-World War II period. One student remembered in an interview with David Baird that “cadavers were kept in a crude cement tank in the basement of the building and when needed were fished out with a hook attached to a long pole. Some would-be physicians never pursued their medical career beyond that particular experience.”³⁷ The school continued to struggle throughout the 1930s, and was finally dropped from the approved list of medical schools by the American Medical Association in 1938. The state did eventually rally around the school, and a beer and alcohol tax was enacted in 1939 that specifically went to school improvement.³⁸ Things really improved during World War II because of the increase in government grants and war time monies.³⁹ In 1951, the governor also secured a large amount of funding for the school through the collection of cigarette taxes.⁴⁰

As in other states, the name of Arkansas’s original medical school also went through several changes. In 1899, it became the University of Arkansas Medical Department. In 1918, it was the University of Arkansas School of Medicine, and from World War II until the 1970s, it

³⁶ Ibid., 465-466.

³⁷ David Baird, *Medical Education in Arkansas, 1879-1978* (Memphis: Memphis State Press, 1979), 147.

³⁸ See https://library.uams.edu/assets/uams_timeline/timeline.html

³⁹ Baird, *Medical Education*, 67-225.

⁴⁰ See https://library.uams.edu/assets/uams_timeline/timeline.html

was the University of Arkansas Medical Center.⁴¹ Finally, the name was changed in the 1980s to the University of Arkansas for Medical Sciences (UAMS), the name it still has today.

Each of these flagship medical schools was encouraged by their states to open university hospitals or specialty centers for children, all in an effort to serve their communities. Kentucky's medical school opened one in 1930 and Arkansas and South Carolina followed in 1982.⁴² These hospitals partnered with local and national charity institutions, likely creating goodwill in the states and increasing funding to the charities. For instance, in Arkansas, Governor Bill Clinton funneled several million dollars to the UAMS system for the upgrade and expansion of its children's hospital in the 1980s.⁴³

African Americans and women had a more complicated relationships with these medical schools. As mentioned previously, Flexner made some recommendations about giving women more access to medical education. However, he offered no concrete plan, and after publication of his report, those opportunities were greatly reduced. A government publication, *The Outlook for Women in Occupations in the Medical Services*, published in 1945, noted that of the 77 medical schools in the United States, only seven admitted women. There was only one all-women medical school, Women's Medical College. Summarizing the situation of the 1940s, the pamphlet said of women's medical training: "It is possible that women have greater

⁴¹ There is a very detailed timeline of the history of UAMS on the Library's website: https://library.uams.edu/assets/uams_timeline/timeline.html

⁴² Ginger Daril, "Arkansas Children's Hospital," in *Encyclopedia in Arkansas*: <https://encyclopediaofarkansas.net/entries/arkansas-childrens-hospital-ach-2235/>, <https://musc.libguides.com/waring/muschistory/buildingsguide>, and <https://nortonchildrens.com/news/norton-childrens-hospital-125-years/>

⁴³ Ibid.

opportunities than in the past but because their proportion to the total number of medical students being trained is smaller, their gains appear to be less.”⁴⁴

For African Americans, mistrust of the professional medical community simply continued, to be further exacerbated by scandals like the Tuskegee Experiments. In the South, they had unequal access to clinics and education, their overall role in medicine stunted by political issues and racist ideas that persisted in the profession and in medical education. Flexner had suggested that medical education needed to be more open to black students in order to further improve their health and social status, but he only recommended that two black schools remain open: Meharry in Nashville, TN and Howard, in Washington, D.C.

Henry Arthur Callis posed an argument for “The Need and Training of Negro Physicians” in the 1935 *Journal of Negro Education*.⁴⁵ Though there had been massive improvements in white medical education, he declared, “The Negro physicians is in a special class and bears a peculiar burden in this country only because of his racial identity.”⁴⁶ He noted that Meharry and Howard had trained “five of every six colored physicians” in the country.⁴⁷ Callis believed that black students should advocate for themselves and their patients, saying, “The colored physician bears much of the responsibility in the fight for improved clinical and hospital facilities for his patients and for himself, for the elimination of poor housing and unsanitary districts, for the relief of his patients from long hours, poor wages and physically

⁴⁴ Marguerite Wykoff Zapoleon and Elsie Katcher, *The Outlooks for Women In Occupations in the Medical Services: Women Physicians*, Bulletin 203, Number 78 (Washington: U. S. Department of Labor, Women’s Bureau, 1945), 8.

⁴⁵ Henry Arthur Callis, “The Need and Training of Negro Physicians,” *The Journal of Negro Education* 4 (1935): 32-41.

⁴⁶ *Ibid.*, 32

⁴⁷ *Ibid.*, 36.

injurious working conditions, for the improvement of educational facilities in the struggle against ignorance and superstition.”⁴⁸ Callis also suspected it would be a long time before the market was “saturated” with black doctors.

In Kentucky, South Carolina, and Arkansas, medical schools attempted integration to train sufficient numbers of black physicians. Integration in Kentucky moved slowly, even after closure of the only existing black medical school in the state, the Louisville National Medical College.⁴⁹ Though Flexner had noted its plethora of teachers and how clean the school hospital was, he still described the college as small and the qualifications as lax. The school did not survive his critique thus closing off both medical training and most medical care to the African American community.⁵⁰ The University of Louisville did not desegregate until the 1950-1951 session; the school of medicine had its first black faculty member, Dr. Grace Marilynn James, in 1953.

The road to integration at the Medical College of South Carolina was also a long one. The NAACP and African American medical organizations sought a black student to challenge the racial policies at the college in 1951, even offering scholarships to black students, but could not find an applicant in the 1950s. It was not until 1965 that the first black applicant was admitted.⁵¹

⁴⁸ Ibid., 40.

⁴⁹ Earl H. Harley, “The Forgotten History of Defunct Black Medical Schools in the 19th and 20th Centuries and the Impact of the Flexner Report,” *Journal of the National Medical Association* 98 (2006): 1425-1429.

⁵⁰ Daniel E. Bigham, *On Jordan's Banks: Emancipation and Its Aftermath in the Ohio River Valley* (Lexington: University of Kentucky Press, 2006).

⁵¹ Thomas J. Ward, *Black Physicians in the Jim Crow South* (Little Rock: University of Arkansas Press, 2003), 56.

Arkansas was quicker to integrate its medical school. The University of Arkansas School of Medicine admitted Edith Mae Irby in 1948 in the wake of major court rulings that allowed black students into other state schools. Irby was an accomplished student who managed to integrate the school without the need for federal intervention. This was remarkable given the historic fight for desegregation of high schools in Little Rock, Arkansas. In the case of Irby, local politicians spun the issue as an educational and not a racial issue.⁵² That did not mean, however, that racial problems did not exist for Irby at the medical school. For one thing, university administrators questioned whether black students could dissect white cadavers, ensuring once again that dissection remained a highly segregated part of medical training.⁵³ The president of the University of Arkansas welcomed her to the school, but the governor of Arkansas and many citizens were furious.⁵⁴

Despite these hesitant steps toward desegregation and integration of white medical institutions, racial problems and challenges in the South continued. A representative sample of the three states mentioned in this dissertation should elucidate some of the challenges that black men and women as well as white women faced in the aftermath of the Flexner Report. However, this is not a complete nor exhaustive exploration. A secondary study of black medical colleges in the South would be worthwhile for historians.⁵⁵ The problems extended, as seen in the case of

⁵² Venessa Northington Gamble, “‘No struggle, no right, no court battle:’ The 1948 Desegregation of the University of Arkansas School of Medicine,” *Journal of the History of Medicine and the Allied Sciences* 68 (2013): 413.

⁵³ *Ibid.*, 398-399.

⁵⁴ Ward, *Black Physicians*, 54.

⁵⁵ An exciting literature regarding black medical schools has emerged in some very good articles. Please see Earl H. Harley, “The Forgotten History of Defunct Black Medical Schools in the 19th and 20th Centuries and the Impact of the Flexner Report,” *Journal of the National Medical Association* 98 (2006): 1425-1429 and Venessa Northington Gamble, *Making a Place*

Irby, to dissection. This crucial part of medical training remained a highly segregated affair, and anatomical information about diseases continued to be produced at the expense of African Americans.

In the 1970s, the University of Louisville collected oral interviews from local black physicians about their experiences in black medical schools and doctoring in the South that revealed how dissection remained racialized throughout the twentieth century. Dr. Maurice Robb, who had studied at Meharry, said that Meharry had “all black corpses” for the black students to dissect. “They were indigent people and I never did see any white corpse,” Robb continued. “We had formaldehyde vats. We just dumped all of the corpses in there and we'd go down there and pick out. And I'd remember the man ask us, our instructor ask us if you recognized anybody, just come over and whisper to us and we will try to see if we can't move that body, but we didn't recognize anybody.”⁵⁶ Robb also remembered that most of his medical instructors at Meharry were from other countries. This was likely due to the inaccessibility of advanced medical education for African Americans in the United States. Interestingly, at one point in the interview, he was told that at one time in the history of the University of Louisville, there had been different agreements, depending on race, for attaining corpses for dissection in medical classes. Robb knew nothing of such agreements.

Another interviewee who had attended Meharry, Dr. Jesse Bell, spoke about the lack of black doctors and black medical care in Louisville.⁵⁷ He was moved to go into medicine because

for Ourselves: The Black Hospital Movement, 1920-1945 (Oxford: Oxford University Press, 1995) for some representative examples.

⁵⁶ Maurice Rabb, Interview by Dwayne Cox, August 15, 1977, University of Louisville Libraries, https://ohc.library.louisville.edu/ohms/viewer.php?cachefile=404-405_rabb.xml.

⁵⁷ Jesse Bell, Interview by Charles Staiger, April 20, 1977, University of Louisville Libraries, https://ohc.library.louisville.edu/ohms/viewer.php?cachefile=201_bell.xml.

of the close relationship between doctors and their patients in the African American community.⁵⁸ Black doctors were not, however, limited to treating only black patients in Kentucky, he said. Bell treated white patients in his first office in the capital city of the state, Frankfort. His partner physician, who was also African American, treated some of the wealthiest families in that city. Bell was also called on by physicians in other countries to attend conferences. At a medical conference in Japan, he had once commented on the integration of public schools in Little Rock.⁵⁹

When Bell was working in the hospital system in Louisville, there were still laws in the state that forbid bi-racial education. Even so, Bell commented that these laws were circumvented in places like the Louisville Memorial Hospital when black doctors sought more clinical instruction. He recalled that there was “a penalty of fifty dollars per day for whites teaching blacks or black teaching white.”⁶⁰ Without hospitals and doctors looking the other way, black doctors had little opportunities for observation as the community had only two hospitals that admitted black patients: The Red Cross Hospital and the General Hospital. At the same time, black students were legally prevented from studying in schools within a certain distance to white students.⁶¹ New York and other places in the United States did as well, so that to receive advanced education, black physicians like himself had to leave not only the state but the country to get education. He wanted ob-gyn training, and for that he was forced to travel to Vienna.

⁵⁸ Ibid.

⁵⁹ Ibid.

⁶⁰ Ibid.

⁶¹ Andrew J. Castrenze, “Berea College, the Day Law, and Black Education in Kentucky, 1890 to 1920,” M. A. Thesis (Harvard, 2017) and J. R.. Decker, "Berea College v. Kentucky." *Encyclopedia Britannica*: <https://www.britannica.com/event/Berea-College-v-Kentucky>.

When asked about what he believed was the single most important event in desegregation, Bell answered that it was the inclusion of black physicians in medical societies in the South. In Louisville, where Bell practiced, the reigning association was the Jefferson Medical Society. Once it opened its doors to black physicians, they had greater access to observation at hospitals and teaching facilities. These professional affiliations not only allowed black physicians greater opportunities to gain knowledge but also granted them greater prestige in the local black and white communities.⁶²

South Carolina dithered about allowing black physicians to participate in professional medical societies. In 1947, the Medical Society of South Carolina first considered whether “Negro physicians” should be invited to the scientific meetings of the society which were held at the Medical College of South Carolina.⁶³ Even then, black physicians would only be permitted as spectators if it pleased the college. Dr. Kenneth Lynch, Dean of the medical college, said any guests of the society would be welcome to use the facilities, but not until February 2, 1951, did the society officially pass motions to allow black physicians to “attend such Scientific sessions as are deemed suitable by the Program Committee.”⁶⁴ The inclusion of “negro physicians” into such meetings were the beginnings of integration, and by the minutes of 1968 there were legal protections for Charleston’s Roper Hospital that forbid racialized discrimination.⁶⁵

⁶² Ibid.

⁶³ Minutes of Regular Meeting of the Medical Society of South Carolina, Tuesday April 8, 1947. These were viewed online via MUSC: <http://medica.library.musc.edu/msschome.php>. The notations of these minutes will be their Resource Identifier that is given on the MUSC Digital Library Website. The page numbers will correspond to the thumbnails, but these page numbers differ from the manuscript pages.

⁶⁴ MSSC 1947 page 41

⁶⁵ MSSC 1968 page 93-96.

In 1958, during the House Committee on Judiciary Hearings, there were discussions regarding Civil Rights. A black newspaper publisher and progressive leader in South Carolina by the name of John Henry McCray gave a statement discussing the role of African Americans and medicine in his state.⁶⁶ He acknowledged that there were “doctors, dentists, and pharmacists among Negro South Carolinians,” but none of them could be trained in the state, even at the Medical College of South Carolina. Though the state had given the school money and bragged about the many black professionals treating patients throughout South Carolina, they “neglected to explain that it hasn’t gotten around yet to providing any training for them elsewhere in the State, not even under its own separate-but-equal doctrine.”⁶⁷ McCray explained that black professionals went to school at Howard or Meharry even if they received financial assistance from South Carolina. He accused South Carolina of giving out “small sums, described by Negroes as ‘hush money’” to study medicine as long as they got their training elsewhere.⁶⁸

White supremacist ideas had long circulated among lay people and colored their perception of black professionals. Newspapers ran pieces that discussed “the negro problem” and often commented on the professional medical community. A typical article appeared in the Pine Bluff *Daily Graphic* in 1906, titled “What a Woman Thinks: About the Negro Problem.” The author, a Mrs. Pierce, argued that no black professional could be as good as a white one. “Say he is a fine physician, lawyer, bookkeeper, clerk, engineer, master mechanic and all of the

⁶⁶ Sid Bedingfield, *Newspapers Wars: Civil Rights and White Resistance in South Carolina 1935-1965* (Champaign: University of Illinois Press, 2017) and Herb Frazier, “John Henry McCray” in *South Carolina Encyclopedia*: <https://www.scencyclopedia.org/sce/entries/mccray-john-henry/>

⁶⁷ U.S. *Congress House Committee on Judiciary Hearings 1959, Volume 1, Serial No. 5.* (Washington: United States Printing Office, 1959), 552.

⁶⁸ *Ibid.*, 552.

higher vocations,” Pierce mused. “Can he take his place beside the white man of the North or South? No, sir, and he never will.”⁶⁹

Arkansas doctors similarly perceived diseases as inherent to certain races, thereby encouraging a type of scientific racism. A 1939 article about Pellagra and black patients in the *Journal of the Arkansas Medical Society* refuted assumptions that Pellagra was caused by uncleanliness rather than lack of nourishment, but described the illness as “found only among the southern negro population.”⁷⁰ Black patients were not dependable enough to care for themselves, thus playing to prevalent stereotypes about black people at the time. “Any of you who have a large negro practice,” the author ventured, “know how impossible it is to get them to continue any form of treatment after a little improvement is shown.”⁷¹

As with other Southern states, racial issues in Arkansas improved slowly over time. Almost twenty years after the desegregation of Arkansas’s medical school, *Ebony* magazine ran a story about the school’s chief pediatric resident, a black woman by the name of Dr. Joycelyn Elders. “Forgetting the ways of the South and the Little Rock of 1957’s front pages and the fact that the doctor is a Negro woman,” *Ebony* mused, “the parents clasp the doctor’s hands with genuine admiration.”⁷² The magazine celebrated Elders as part of a new bi-racial Little Rock. “In the out-patient clinics, Negroes and whites sit together and talk about their ailments,” the magazine enthused. “Negro nurses are employed, and Negro technicians sit at microscopes in

⁶⁹ “What a Woman Thinks: About the Negro Problem as It Today Involves the South and What She Thinks to Be the Only Remedy,” *Pine Bluff Daily Graphic*, January 14, 1906.

⁷⁰ C. N. Bogart, “Treatment of Non-Institutionalized Cases of Pellagra: With Case Reports,” *Journal of the Arkansas Medical Society* 36 (1939), 45.

⁷¹ *Ibid.*, 46.

⁷² *Ebony*, 19 (April 1964).

the laboratories.”⁷³ Elders was surprisingly generous in her assessment of her time teaching medicine Little Rock. She noted that she treated mostly rural Arkansians and her students also come from rural areas of the state. *Ebony* interviewed the head nurse in the pediatric unit, Jo Herring, who was quoted as saying, “When we think of her, we forget all about what color she is....To us, she’s just Dr. Elders, our Joycelyn. And I’ll tell you something, mister. She’s a real humdinger!”⁷⁴ Elders would go on to be Surgeon General under President Clinton.⁷⁵

In 1975, Dr. Henry G. Hollenberg was given the job of writing a brief centennial history of medical developments in Little Rock, for *An Anthology of Arkansas Medicine*. Unlike many of the institutional histories used to provide a background structure for telling stories about a school, his study was less self-congratulatory than the rest. Hollenberg did talk about the successes of Little Rock physicians in building hospitals and the school as well as in expanding the local medical profession to include women, but he ended the piece by looking forward to what medicine might be like in 2075. “[Future doctors] will be aghast at our brutal attack on cancer by surgery, on our fumbling attack by chemotherapy, our hopelessness in dealing with arteriosclerosis, our poor understanding of mental derangements...and many other conditions poorly treated now. It behooves us to be not one bit smug, but on the other hand, rather humble about our present capabilities and hopeful for great further progress.”⁷⁶

⁷³ *Ibid.*

⁷⁴ *Ibid.*

⁷⁵ See https://cfmedicine.nlm.nih.gov/physicians/biography_98.html

⁷⁶ Henry G. Hollenberg, “Centennial Medical History of Little Rock and Central Arkansas,” 24 in *An Anthology of Arkansas Medicine* ed. Horace N. Marvin (Fort Smith: Arkansas Medical Society, 1975).

It is easy to look back on the stories of these schools and become consumed with wonder for what nineteenth-century practitioners managed to accomplish. It is also easy, as so often happens, to be blind to the pain that medical schools sometimes inflicted on their patients and medical communities in our reflection on the praise these same institutions received from earlier historians and their contemporaries. As David Baird said, “That [the founders of Arkansas’s medical school] were at the same time altruistic and self-serving was fortunate. They knew that no institution could long survive without some of both, and that a proper mix of each would ensure long-term success.”⁷⁷ How do we balance these qualities in our assessment of those early doctors? Institutional histories have, on the whole, certainly contained a fair amount of smugness, and much of that has no doubt come from the fact that Southern medical schools appear to overcome greater obstacles than more widely admired and respected Northern ones.

Today, medical schools in Kentucky, South Carolina, and Arkansas have radically different goals and ways of thinking than when they were founded. The current mission of the Medical University of South Carolina states, “As a college dedicated to educating a diverse range of health professionals, we benefit our students, the University, and community through our synergistic approach to creating new knowledge and expertise.”⁷⁸ The University of Louisville School of Medicine’s mission is “to improve the health of our patients and the diverse communities we serve through excellence and leadership in education, patient care, research, and community engagement.”⁷⁹ Finally, the University of Arkansas for Medical Science’s mission statement emphasizes the need of “providing high-quality, innovative, patient- and family-

⁷⁷ Baird, *Medical Education in Arkansas*, 45.

⁷⁸ See <https://chp.musc.edu/about/vision>

⁷⁹ See <https://catalog.louisville.edu/professional/medical-bulletin/about/mission/>

centered health care and also providing specialty expertise not routinely available in community settings.”⁸⁰ All three schools’ emphasize through their promotional literature and websites a desire to promote collegiality and professional collaboration as well.

These mission statements of today are at odds with the creation and founding of the same medical schools in the early nineteenth century. Doctors then battled each other for reputational integrity while working at the contradictory goal of trying to promote their medical schools. One thing that has not changed, however, has been the emphasis on community approval and engagement. The inclusiveness of the community the schools appealed to has changed, but not the idea that a school had a job to serve the city around it. The white doctors who founded the schools in Kentucky, South Carolina, and Arkansas were Southern doctors described as serving their communities, but so was Dr. Joycelyn Elders.

The story of Southern medical professionalization may have laid a pathway for future progress, but it was not victimless. There are still obstacles to healthcare for minorities in the South and a legacy of abuse that needs a reckoning. At the same time, many people now donate their bodies to medical schools with pride. Physicians and medical schools had to be good at public relations, but it is no surprise that money and state-absorption were ultimately what fixed medical education. In a profession that claims its ultimate responsibility is to “first do no harm,” they started off by doing a lot of it, especially in the South. Efforts to patch up the reputation of physicians are reflected in the attempts of medical schools to prioritize diversity, professional cooperation, and community service, even today.

⁸⁰ See <https://web.uams.edu/about/vision-mission-core-values/>

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