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Psychiatry and Civil Rights in the American
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Introduction

CHRISTOPHER BRICK: Hello everyone and welcome back to the *Intervals* podcast. We are a public humanities initiative of the Organization of American Historians and I'm Christopher Brick, here on behalf of the OAH Committee on Marketing and Communications, and here as well to welcome our 15th guest lecturer of the series.

Dr. Kylie Smith is with us today from Emory, where she's an associate professor with a special research emphasis on the history of nursing and psychiatry.

And here a bit of background context is not just relevant, but useful. One of the reasons why the OAH and my colleagues on the Marketing and

Communications committee wanted to organize a public history initiative of this sort, at this moment, is because of the time.

Right now in the United States there is a robust argument taking place, throughout the culture, really, about divergent readings of the American past. And we felt obliged to be additive to that exchange with content that was topical to it. And one of the reasons why we at the committee were grateful to be able to include Kylie's work as part of this series is because it is so responsive to that purpose.

The past can be and often is harrowing; but when it brings us closer to a truthful accounting of events, and to a truthful accounting of events of racial violence--in particular a theme that's evident throughout this podcast, throughout the history of public health, and throughout the history of the United States. To the extent that it can get us a little bit closer to a truthful accounting of that story then we at the pod also felt like it could do a little something to reckon with that legacy.

It's really the most necessary kind of work right now and we're delighted to be able to share it with you today.

Please do continue sending us your feedback, comments, and questions. They've all been really helpful and we appreciate them. Our contact info is in the episode notes. And with that I yield the floor, very gratefully, to Prof. Kylie Smith on "Jim Crow and the Asylum: Psychiatry and Civil Rights in the American South."

Lecture

KYLIE SMITH: Hello, my name's Dr. Kylie Smith and I'm an associate professor and the Andrew W. Mellon Faculty Fellow for Nursing and the Humanities at Emory University in Atlanta.

My first book was about the history of American psychiatric nursing. And while I was researching that book, I came across some interesting evidence about southern psychiatry. That's led me to my new project, which is what I'm going to talk about here today. This new project is called "Jim Crow in the Asylum: Psychiatry and Civil Rights in the American South."

Last year I received a grant from the National Library of Medicine to travel to archives in Georgia, Alabama, and Mississippi for this project, which started as an interest in the impact of the Civil Rights Act of 1964 on southern psychiatric hospitals.

I was interested in trying to understand to what extent the history of racial segregation that had led to current disparities in mental health care either through a lack of funding or lack of services. I also wanted to try and understand how other legislation in the 1960s, like the Community Mental Health Act of 1963 and the Social Security Amendments of 1965, which introduced Medicare and Medicaid, had affected the treatment and care options for African American patients in the South.

And, theoretically, I wanted to try to understand the tension between care and control in psychiatric services, especially in the context of a long history of white supremacy, racism, and eugenics in the south. This is still very much a work in

progress, and I can't cover it all today, but I am going to try to share some examples of the kinds of materials I've come across and what it can tell us about life in southern psychiatric hospitals for African Americans in the 1960s.

First though, a note on sources. Of course, this is a project that depends largely on what is available in the records. My research so far has taken me to archives across Georgia, Alabama, and Mississippi and revealed much more than I bargained for, but also has come with some serious obstacles. In the wake of HIPPA, state and national archives have become super sensitive about records related to mental health. More than once, I've had to watch as boxes with potentially useful information are literally taken off my cart in front of me.

Even though I have an IRB ruling and I explain to archivists that I'm aware of the privacy legislation and am not looking explicitly for patient records, and of course I would not identify anyone anyway. Anything they can give me, some insight into the patient experience, is regularly restricted from view. And sometimes, southern archives themselves, especially anything from the 1960s and related to civil rights, can be disorganized, uncatalogued, and sometimes deliberately hidden. There's also no consistency to the way records are kept from one state to the next and that makes cross-state comparisons difficult.

But I have been able to talk to people who have either worked in some of these institutions or were lawyers on some civil rights and patients' rights cases. These legal files have been especially useful because civil rights courts are not generally interested in hiding the truth and it's often civil rights lawyers and activists who

exposed bad conditions. Legal cases have also been interesting because they've demonstrated the historical connection between psychiatric and carceral networks in these states.

One of the things that immediately became visible to me early in my research is that there were close connections between these systems. That Black people with mental illness or developmental disability usually found themselves confined in one or other of these institutions and that sometimes there were direct pathways and transfers between them. If we think of hospitals as being part of this network of broader confinement, then we have to think about the ways that they existed in the context of the fight over white supremacy in the south.

But what does it mean to say that psychiatric hospitals operated as part of a broader system of white supremacy? I mean that long after the Civil War, both law and everyday practice in some southern states was enacted with the explicit purpose of recreating and reinforcing hierarchical white over Black relations. Medical and psychiatric discourses and practices were essential to this process. In the rest of this lecture, I'm going to talk about the way we see white supremacy rear its head in southern psychiatric hospitals through an analysis of attitudes, conditions, and a look at some diagnostic and treatment disparities.

So, let's look at attitudes first. Theorists and historians have demonstrated the long history of medicine's role in the creation and perpetuation of racial thinking. Inextricably linked to colonialism was the idea that conquered and Native people were inherently less than human, at best the "noble savage," at worst, suited only for exploitation and

oppression. In the American setting, this took a particularly virulent form with the idea that the Black body and mind was suitable only for work in the fields and was not capable of the same range of feeling or emotion as white people.

These ideas were made most notoriously famous by physicians like Samuel Cartwright, who spent precious time inventing mental illnesses that didn't exist as justification for the enslavement and abuse of human beings. If you're listening to this, you're probably already familiar with his work, but here's a quick refresher.

In 1851, Cartwright published a report entitled "The Diseases and Physical Peculiarities of the Negro Race." In this report he invented two psychiatric disorders, drapetomania and dysaesthesia aethiopica, to explain the tendencies of enslaved people to run away or to resist hard work as a form of mental illness. Cartwright also claimed that enslaved people demonstrated child-like simplicity and lack of emotional processes which he claimed were characteristics of their entire race. In this report and in others like it, physicians argued that slavery was the natural state for the African in America because they benefited from the hard work and were incapable of looking after themselves outside the system.

Cartwright was not an outlier. The idea that African American minds and bodies were inherently different to white ones, and usually different in the wrong way, was an essential theme in the development of American medicine broadly. That would take a whole other lecture to explain, so for today it's enough to say that Cartwright's ideas continued to resonate with American medicine and psychiatry for at least another century.

Central to these ideas is the belief that African American patient was already deficient in some way, which was reinforced by segregation and the terrible conditions for African American patients. In terms of conditions, segregation was the first and primary strategy for dealing with Black patients in all hospitals across the south without exception well into the 1960s.

This took different forms in different places. Both Central State Hospital in Georgia and Whitfield Hospital in Mississippi had Black and white patients on the same campus but separated them into different buildings. Alabama was the most obviously racially segregated. In 1902 it opened Searcy Hospital on the grounds of the old war fort in Mt. Vernon, thirty miles north of Mobile, and moved most African American patients there. Some patients did stay on the campus at Bryce Hospital in Tuscaloosa, but mostly this was to work on the farm—and I'll explain more about that in a minute.

Segregation of Black and white patients needs to be understood not just as the way things were back then or as a simple byproduct of general racism, but rather as an active and deliberate technique of a white supremacy that was steeped in the ideology of eugenics and its fear of miscegenation. Eugenic thinking was central to the reorganization of the new south in the early 20th century. Its practitioners, who were also often the people who ran state hospitals, drew on existing racist ideas about the basic inferiority of African Americans, combined with a belief in their ability and their authority to control reproduction for the betterment of the white race. This is not just my interpretation as a historian, these were the actual stated claims of physicians, psychiatrists, and administrators at the time, who ran the

institutions as catch-alls for people considered a threat to the reproductive integrity of whiteness.

This is one reason these institutions get so overcrowded. They were often the only public facilities in their respective states and became warehouses for both Black and white developmentally disabled, elderly, alcoholic, and mentally ill people. Procedures for admission were ad hoc family or community members including the police, who'd easily petition in a probate court for a person to be admitted with no medical evidence necessary. Once admitted they were at the mercy of an underfunded, overcrowded system that really operated as custodial institutions rather than places of treatment and care.

For many African American patients, however, segregation was the most benign manifestation of white supremacy, but it did not go unchallenged. From the late 1940s, using papers from the NAACP Legal Defense Fund, I've begun to find evidence of whistleblowers and other community activists concerned about, not just segregation as a civil rights issue, but explicitly with the way that African American patients were being treated.

At Whitfield Hospital in Mississippi for example, African American patients were on the same campus as white patients, but in separate buildings, sometimes in basements, often shackled. If a patient was able-bodied, they were put to work on the hospital farm. There was no oversight, no inspections, no statements or health board. Attendants and medical staff were all white and they were underpaid and not trained. The racial dynamics were at best hostile, at worst deadly.

In 1947, the National Association for the Advancement of Colored People received this letter

from a worker at Whitfield, which I will quote verbatim: "Dear Sirs, I've been chief of patrol at the state hospital for the insane people at Whitfield Miss for several months and they are making slaves out of the colored patients out there. They work them from before day to after dark. One of the big shots by the name of Stag shot one of the patient's eyes out and the day superintendent by the name of Smith carries a gun all the time. I'm turning my resignation in and quitting. Please do not mention my name. Yours Truly, Hal Watkins."

There's a lot to consider in this letter. For a letter to come to the NAACP from a white man in Mississippi, because Mr. Watkins was undoubtedly white, is extraordinary. The NAACP received a number of letters like this starting after World War II, either from concerned patients' rights organizations or patients or workers themselves. This is one of the earliest and it's the only one I've found from Mississippi so far. It's significant because it speaks to the existence of a moderate white counter narrative to the tactics of white supremacy, at the same time as it reveals the way that even a psychiatric hospital continued to replicate plantation relations of fear and violence.

Watkins refers to the way that patients were being worked like slaves, as well as the threat of and actual violence under which they were forced to live. The work that Watkins is referring to is the asylum farm. Whitfield sat on three and a half thousand acres of prime land and ran an extensive planting crops and livestock enterprise including its own dairy. Black patients worked that farm under the guise of agricultural therapy, but

therapy exercised at the point of a gun is no therapy at all.

At the time of this incident, Whitfield was in a dire situation. World War II had drained the state of medical personnel and money for public services. I doubt much would have changed except that a white patient, Fred Cheney wrote a series of letters about conditions which a worker smuggled out to the slightly liberal newspaper editor Hodding Carter of the Greenville Democrat Times. Carter was relentless in his campaign against state corruption and the articles he wrote based on Cheney's letters forced a legislative commission and a governor's tour of the facility, which led to a commitment of money for renovations and a new administration.

In 1949, the state hired Dr. William Jaquith, a navy physician, to be the new superintendent at Whitfield. Later in his life, Dr. Jaquith recorded his first impressions of the hospital.

"When I first came, I was appalled at what I saw," he said, "I almost left immediately. I was so upset with the total picture. Things were terrible, it made grown men cry. I was the only physician for ten buildings and eight hundred patients. The buildings were in a terrible state of disrepair. The patients slept on handmaid mattresses; sacks stuffed with hay." He told of how the patients had an incomplete diet with a total caloric intake of less than eight hundred calories a day and "many patients suffered from malnutrition, it reminded me of a POW camp. It was the result of complete public and legislative apathy."

Jaquith was on a constant campaign to raise the state appropriation for the hospital. When he took it over, he was feeding patients on only ninety-eight cents a day per patient. By 1963, with an in-

patient population of four and a half thousand, half of whom were Black, Jaquith reported that expenditure had risen to only two dollars thirty-seven per patient per day, which was still the lowest expenditure for mental patients in the nation.

Jaquith's concern for conditions did not necessarily extend to the African American patient. In a report to the state department in 1951, he wrote, quote, "the hospital is very overcrowded at the time, especially infirmaries where the old and senile are housed. The Negro section of the hospital is overflowing, and we have had to open up basement space for the overflow. Two of our Negro patients' buildings are used as housing quarters for employees. There's no relief in sight at the moment to transfer Negro mental defectives."

Jaquith's aim with this report is not necessarily to garner sympathy for Black patients, rather it's to further enforce and entrench segregation. His intention was to bring to the attention of the board of trustees and the state department how bad things were for white patients and employees as part of his repeated request for more funding. If he was moving Black patients into the basement, the problem was not that they were in the basement, but that his other, largely white employees had to live in accommodations that were previously only fit for Black patients. Interestingly though, Jaquith had no patients work the farm and saw it for what it was. In 1950, "I told them I'd never been a farmer," he said, "we closed the farm and the dairy herd. If a patient was well enough to work here, he was well enough to be at home."

This was not the attitude of administrators in either Alabama or Georgia, both of which continued

to run farms into the 1960s. Georgia's farming operation is complicated because it overlapped with the George State Prison farm and I'm still figuring out how they worked. But I have a much clearer picture of the farm operations in Alabama, thanks to the efforts of local NAACP activists and lawyers.

From the 1950s, General LaFleur, ex-Secretary of the Mobile branch of the NAACP before it was banned by the Alabama government, in his new role as the Director of Casework for the Non-partisan Voters League, began to receive letters of complaints from workers and family members associated with Searcy Hospital in Mobile. In the 1950s, he wrote to the government of Alabama complaining about segregation in pay and conditions for workers but received no response. In the 1960s, he took up the case again with complaints, letters, and a petition about conditions and segregation. In 1963, the NAACP Legal Defense Fund won a big case in North Carolina called *Simkins v. Cone Memorial Hospital*, which made segregation in medical facilities unconstitutional, and this was reinforced by Title VI in the Civil Rights Act in '64.

LaFleur used these legislative moments to constantly advocate for change at Searcy Hospital, which was close enough for him to visit. In 1966, Henry Styles, a law student and intern with the Civil Rights Research Council, worked with LaFleur to investigate complaints from patients' family members.

LaFleur's files contain handwritten notes detailing a plantation-like system where, quote, "both Negro men and women are transferred to Bryce Hospital, Tuscaloosa and North Port for farming. Negroes stay on farm at North Port, some of whom are transported

by bus or truck to Bryce then return to North Port each day."

North Port was the site of Bryce treatment center too but the only form of treatment here was work on the farm. Patients transported to Bryce itself worked in the laundry and kitchen. The notes also document that white employees were able to take Negro patients home to work in their house and return them at the end of the day, nothing short of a kind of convict placing system.

Farms and work are not uncommon in psychiatric institutions. The idea of work as therapy built on a long tradition of what was called moral treatment, when work and occupation were believed to be therapeutic. But in the South, these practices lingered long after they'd been eradicated elsewhere, serving as a powerful reminder of the prevailing social order.

Styles and LaFleur, as well as respective governors, also received numerous reports of brutality and evidence of overt white supremacist violence within the psychiatric hospitals.

In an affidavit, Mrs. Brown reported that her son, Joe Nathan Jr., a patient at Searcy Hospital, had been, quote, "beaten by two white hospital employees named Johnson and Newton. My son took his father and me to one of the toilets and showed us welts and blisters on his left buttock which he said resulted from the two white men beating him up with a cut-off water hose. He explained that one of the men held him while the other one beat him after locking him up."

While beatings and abuse are a common problem across badly managed and overcrowded psychiatric institutions, Mrs. Brown was in no doubt about the

racial implications of this attack, which she believed, quote, "was due to strong race prejudice in view of the fact that a number of white employees of this hospital are alleged to be members of the Ku Klux Klan."

This is not mere anecdote, as Mrs. Brown stated, white employees of the hospital were in fact arrested only the previous week after participating in a Klan rally at Mt. Vernon and shooting into the house of a Negro woman and attempting to burn down her house.

LaFleur's continual activism finally led to the arrival of federal government inspectors in Alabama. The Department of Health, Education and Welfare had established a small office, the Office of Equal Health Opportunity in 1965, in order to force compliance with the Civil Rights Act. In late 1966, the office sent its special council, Marilyn Rose, to see for herself the conditions that prevailed in Alabama.

In an interview conducted in 1997, Rose remembered her visit to Alabama, quote, "while the staffing and service at Bryce as a whole were a mixed bag, services for patients at Searcy were custodial and the general wards were horrid. There were only five doctors, four of whom were foreign whose primarily language was not English. They were not licensed in the United States and did not have credentials as psychiatrists in their native country. The fifth psychiatrist was the administrator, obviously not conversant with one psychiatry and seemed to be running a southern plantation. A visit to the ward suggested to me what one might have found in the 19th century, at a time when mental patients were warehoused. The wards were like prison cells, it was a scene out of a Kafka play."

After her inspection, Rose documented her findings in a formal report to the Surgeon General. While the documents did not detail the specifics of treatment, they do note that no Black patients were part of a large public health service grant for young men with schizophrenia and that inferiority in treatment and care was compounded by discrimination and lack of spending and staffing. The documents also noted that there were no Black professional staff members such as physicians, psychologists, and nurses at the three institutions. While Bryce Hospital offered extensive nurse training for schools throughout the state, which supplied ready labor, no nurses training program had ever existed or been sought at Searcy.

Similarly, expenditures at Searcy were proportionally lower per patient than at Bryce and Searcy had never applied for any public health service grants. Rose's observations demonstrate that separate but equal was never a reality in medical or psychiatric facilities in Alabama. Instead, the practice had created a space where people could be removed from visibility entirely and where Black patients existed in almost a complete vacuum of approaches to treatment or care.

In this broader context of the long history of racist attitudes about the Black psyche and the continuation of plantation practices, it's hardly surprising that we would find vast disparities in both diagnosis and treatment of Black patients compared to white. Here again I run into an issue of records, or the silences they contain. There is no standardized way that each of the three states in my study kept records, so clear comparison across time becomes difficult. I said earlier that I was not pursuing patient records, but even the

formal institution records are patchy. Annual or bi-annual reports, formal documents usually compiled by the respective institution superintendent, survive from the 1950s but taper out in the 1960s.

Even so, I have some interesting data samples from Georgia and Alabama that I think are particularly interesting. So, let's look at Georgia first, where I have annual reports from Central State Hospital. These reports are relatively comprehensive up until about 1963, and then a few things start to change like the way that people are categorized racially and the amount of detail that's collected. But up until '63, the hospital's records at first compiled very detailed tables for the annual report. These tables set out patient data registered by first admission and then readmission, broken down by race and gender in an overall summary table, and then further breakdowns by race, age, and gender within each diagnostic category.

In 1963, Central State logged a total population of 12,014 people, making it one of the largest psychiatric hospitals in the world. The population breakdown demonstrates that white women were the largest population with 4,145, white men at 3,454, non-white women at 2,332, and non-white men at 2,083. It's impossible in the time I have here to give you a comprehensive overview of the diagnostic breakdown, so I just wanted to present some data relating to the top diagnostic categories.

In terms of a reference for diagnosis, Central State is using DSM-1, which dates from 1952 and won't change until 1968. That's the main diagnostic manual for American psychiatry. So, the tables in the annual report set out rates and types of diagnosis are organized into larger groupings like

acute brain syndrome, chronic brain syndrome, psychotic reactions, personality disorders, transient situational personality disorder, and mental deficiency.

In 1963, the top three diagnostic categories are schizophrenia, mental deficiency, and depressive reactions. Together, these diagnoses accounted for 9,700 of the total 12,000 diagnoses. So, let's take a closer look at schizophrenia. 5,220 people were given this diagnosis. Of this total, 35.5% were white women, 25% white men, 20% non-white women and 17% non-white men. Historically, that's not particularly surprising. Schizophrenia was largely considered a white woman's disease at this point in time and wouldn't start to shift towards Black men until after the civil rights movement.

But if I flip my analysis away from the diagnostic category itself and look at the prevalence of a diagnosis within each racial category, we see that, in fact, schizophrenia generally was diagnosed among non-white patients proportionally more than white ones, with this diagnosis accounting for 46.6% of the diagnoses for Black women. There's not a huge gap between Black and white women here, with 45% of white women given this diagnosis, but that gap widens when it comes to men; 43% of Black men diagnosed as schizophrenic compared to only 38% of the white men.

This same sort of pattern holds for depressive reactions. I was surprised to find that Black women are the largest group diagnosed here, accounting for 35% of the total depression diagnosis, while white women accounted for 30%, Black men 21%, and white men only 13%. Within the group of Black women, depression accounts for nearly 14% of all of

their diagnoses, 9% for Black men, and 6% for white women, and only 3.5% for white men.

Mental deficiency is an interesting category, it accounts for almost all of what we would now call developmental or intellectual disability from very low IQ to down syndrome and autism. Here we see an over-representation in terms of white men, who are actually only 28% of the population, yet they account for 36% of those classified as mentally deficient; while white women are 27% of the diagnoses here, non-white men are 21% and non-white women 15%.

When we look at these diagnoses as a percent of the diagnoses within each racial group population, we see that in this instance the disparities fall along gender lines; 20% of the white men and 19% of the Black men, compared to nearly 13% of the white women and just over 12% of the Black women receiving this diagnosis. What does all of this mean? While I still need to do more work with these statistics and they really only make sense if we can look at change over time, I think the most interesting thing that I found so far is that Black people are more likely to be classified as either schizophrenic or depressed than white people and that these two diagnoses make up the bulk of diagnoses for those populations.

For Black women in particular, these three diagnoses account for more than 72% of their total diagnoses, followed closely by 71% for Black men. In comparison, for white women, the top three account for 65% of their diagnoses and only 62% for white men. So, my hypothesis here, is that there is less of a range of diagnoses being used for non-white people, indicating a lack of complexity and a

lack of nuance when it comes to diagnosing the more subjective personality disorders.

Black women in particular are more likely to be labeled a schizophrenic than anyone else. In the absence of detailed and individual case files, I can only theorize about why this might be the case. Given the broader social context and the long history of eugenics thinking and practice, I don't think it's too much of a stretch to link older ideas about the lack of complexity in the Black psyche to these diagnostic trends in the 1960s.

Also largely absent in the records is information about how people were treated once a diagnosis was made. And none of these annual reports from Central State present any coherent information about that, apart from references to the pharmaceutical budget. This is also largely the case in Mississippi and Alabama, although I do have one interesting set of comparative data from the annual reports in Alabama in relation to the use of electroshock therapy, as it was called at the time—and I'll just call it EST from here.

I have some data that shows several differences in the use of EST for white and Black patients, and I was able to run a comparison between 1954 and 1964. The most telling numbers here are the instances of EST presented as a percentage of patients, that is in 1954 almost 42% of the population at Searcy hospital, the Black-only facility in Mobile, received some kind of EST; but, generally, less instances per person on average, meaning it's more widespread. At Bryce Hospital, by comparison, roughly 20% of the population received some kind of electroshock therapy. In 1964, this has changed so that less people overall are receiving EST. At Searcy it's come down from 1,100 to 517 and at

Bryce down from 1,026 to 720, which reflects a general move away from this treatment to psychotropic drugs like Thorazine.

But the rates of treatment for Black patients is still almost double than that of white. At Searcy, still 19.6% of the population are receiving EST, while at Bryce, which is still all white patients, only 11% are subject to shock therapy. Again, what are we to make of this discrepancy? There's no explanation given in the reports, and I have no evidence of any therapeutic rationale. Except I would argue for the persistence of the belief among Alabama physicians that the African American was more aggressive, more dangerous and less qualified for psychotherapeutic approaches. The prevalence of schizophrenia as a diagnosis and the use of labor and EST as treatment regimens speak to a persistent belief that African American mental illness was located in the body and could be treated in the same way, often violently.

This kind of data also speaks to the tension between care and control in the treatment of African American mental illness and here I defer to the experience of the community itself. As John LaFleur in Mobile worked to build a case against segregation and abuse in Alabama psychiatric hospitals, local people were outspoken about their own belief in the way that psychiatry was being used as a form of social control linked to white supremacy. The civil rights newspaper *The Southern Courier* ran a surprising large number of stories about the Alabama mental hospitals and followed a desegregation case closely. It provides some first-hand account of conditions at Searcy and gives a rare glimpse into the experience of patients and families.

Throughout 1966 and 1967, the paper ran a number of stories about patient activism and the way that Searcy hospital was used as a place of control and punishment.

On March 12, 1966, for example, a letter to the editor reported, quote, "On the 15th of February the patients at Searcy Hospital marched for better food and better clothing. They also marched at the front office to see Dr. Rowe about getting better treatment from white employees. They say the white employees curse them out and throw their food to them when they go to the canteen. After the march some of the police came to the front office of Dr. Rowe and handcuffed some of the patients."

A series of articles about the experience of Ms. Prewitt also demonstrated the way that people can be confined against their will for no real reason and with no real medical oversight. In June 1967, Ms. Prewitt was committed to Searcy because she argued with an administrator at the Mobile General Hospital about her entitlement to benefits.

Ms. Prewitt suffered from no more than a disability in her left leg, yet she was committed to Searcy by a doctor at Mobile General who said, quote, "'I looked her over and classified her as paranoid schizophrenic,' the doctor said last week. Of course, he added, 'I'm no psychiatrist.'"

Once admitted, Ms. Prewitt was submitted to three round of electroshock treatment against her will. Superintendent Dr. Rowe justified the treatment by arguing that, quote, "'after a patient is legally committed, we give them the treatment we think they need. She did cause quite a bit of disturbance,' Rowe said about Ms. Prewitt, 'but she was improving.'"

For the superintendent, improvement meant compliance, silence, and obedience. Ms. Prewitt was released because of the continued protest of some local white women, but for the patients who remained the situation was dire.

In one story, the paper reported many of the same conditions that the health inspector, Marilyn Rose, had found: a lack of good food, unsanitary and overcrowded lodgings, abuse by white workers, and enforced labor.

The paper reported, quote, "you can buy food at the patient canteen. The canteen is run by white people. The food you get there is thrown, not handed to you, like you're a dog. Some patients volunteer to work, but others are forced. They carry clothes on their back to the laundry, rain or shine. If they're not there, they're looked for as if they were paid to work, men and women. Some women go to the field to work the garden. About two of the patients worked for Dr. Harry Rowe; he gives them a very, very small salary. If you talk back to an attendant or 'sass' them, as they call it, you're given electroshock treatment. All the attendant has to say is 'I want this patient shocked' and the patient is taken in for a treatment. The usual treatment is ten shocks but sometimes it is more. If the patients refuse to eat the half cooked or dirty food, they are sometimes given shock treatments. A lot of patients have been shocked and never awakened again."

At the end of this powerful article, the writer argues that the only solution is integration. The belief that conditions would only improve if Black and white patients were treated together formed the impetus for medical civil rights cases in the same way as it had for educational integration.

Alabama's continued refusal to voluntarily integrate its mental health facilities finally led to a court case in that state, fueled by the investigations of LaFleur and Marilyn Rose at HEW.

On November 17, 1967, a complaint in a case called Marable vs Alabama Mental Health Board, which was a class action on behalf of patients, was filed in the district court by the DOJ and the LDS Jack Greenberg, Michael Meltsner and Conrad Harper along with Birmingham civil rights attorneys Orzell Billingsley and Demetrius Newton. The named plaintiffs were Loveman Marable from Bryce Hospital, a client of Newtons, and Joe Nathan Brown Jr. from Searcy Hospital, the subject of the affidavit secured by LaFleur in August 1966.

This case was consolidated with another case lodged by the state of Alabama arguing that the federal decision to withhold funding because of non-compliance with the civil rights act was a breach of states' rights. Together, the cases fell under the purview of civil rights upholder Judge Frank N. Johnson Jr., who had no patience with Alabama's political game playing.

On February 11, 1969, the court handed down its finding in what Judge Johnson described as, quote, "long and complicated litigation over a rather straight-forward problem," that segregation in Alabama's hospitals was illegal and unconstitutional.

He gave officials twelve months to integrate Bryce and Searcy's patient population and declared sections of Title 45 of the Alabama code, which allowed admission without due process, in violation of the 14th amendment. For Johnson, the cases were an important part of his own overall strategy of using judicial activism to fight desegregation in

all areas in Alabama. He likened his approach in these mental health cases to the way he had ruled in educational segregation, quote, "that the patients were entitled to non-racial staff assignments." Johnson signaled his intention to do more than just rule against the state, but also to demand affirmative action in the transfer of patients, the employment of staff, and in the paying conditions for employees.

In his final ruling in *Marable vs Alabama Mental Health Board*, Johnson also noted that the record, quote, "reveals considerable expert testimony to the effect that there is no medical justification for the segregation of patients and personnel in the Alabama mental health system."

While he reserved the right for physicians to make medical decisions that included the patient fears and delusions, he warned the state that, quote, "racial classifications are always subject," and that medical justifications for segregation would not fare well in his court. He also ordered that the administrators of the Alabama mental health system report to the court on their integration progress every six months, until the court was satisfied.

The extent to which the case led directly to integration, however, is blurred by the impact of other moments in the care of the mentally ill. The Community Mental Health Act and Medicare, along with Johnson's rulings in another significant mental health case, *Wyatt vs Stickney*, combined with other cases about the need for minimum standards and a right to treatment, forced a rapid downsizing of institutional care across the U.S. This trans-institutionalization meant that the state could shift the burden of care to nursing

homes, general hospitals, and eventually to prisons.

Similarly, the court finding that there was no medical justification for separate and unequal treatment based on race did not miraculously end the practice. The idea that it was no longer acceptable to talk about racial segregation created a kind of race-neutral language that worked to hide continued disparities because many mental health institutions stopped recording the race of patients entirely. This was reinforced by the same freedom of choice rhetoric that was being used to justify continued educational segregation.

In the case of mental health, families and relatives of patients were now free to have patients committed to any institution, usually the one closest to home, thereby reinforcing existing geographical segregation. At the same time, the rhetoric of racial difference between the white and Black psyche found new forms of expression in the marketing of race specific drugs just as science and changing diagnostic criteria, which now cast the African American man as inherently more aggressive.

This is not new rhetoric, merely a repackaging of much older ideas in the history of American psychiatry and medicine. Of course, none of these ideas or practices were news to African Americans themselves. They knew all too well that medical spaces were not necessarily safe ones and that the institutions that purported to care for them were in no way exempt from the rhetorical and actual violence of white supremacy. Patients, relatives, and activists approached those institutions with caution, yet continued to demand their rights as citizens and taxpayers. It was through these

demands that activists sought to end Jim Crow in the asylum.

Today, all three of these states are in court over the lack of mental health funding for prisoners. These big hospitals, in their original form, no longer exist, but the poor and people of color across the South continue to find themselves at the mercy of separate and unequal mental health care as white supremacy is remade beyond the asylum walls.

Q+A

[segue from lecture]

CHRISTOPHER BRICK: It probably won't surprise you to learn that after listening to that I had plenty of questions. I'm sure you do as well. I hope I've done a good job of anticipating some of the ones you would've asked yourself. Enjoy.

[beginning of group conversation]

CHRISTOPHER BRICK: Kylie Smith, welcome to the podcast!

KYLIE SMITH: Thank you for having me!

CHRISTOPHER BRICK: It's our pleasure, and thanks for the lecture, too— there was a lot in there! So I took some notes and I wanted to get to as much as we possibly can in the short time that we have.

I guess I want to start here; at one point, sort of an earlier part of your lecture, you talk about your interest in *Southern* psychiatry. You characterize it that way, and I think for many listeners, it's going to come as a bit of a surprise that there are regional variations to

medical practice that warrant historical inspection.

KYLIE SMITH: Yeah, I often get asked about "What is the difference between Northern and Southern psychiatry, if you can make that distinction?" And sometimes you can and sometimes you can't. It depends on the time; if I think about what's happening in the South after World War II in the 1950's and the early 1960's, there is a kind of distinct difference, in some ways, that is born out of the reality that education is still segregated—very highly segregated. So, there's actually very little opportunity for Southern medical and health professionals to get educated in psychiatry and they tend to have to travel north. And that's definitely the case for Black healthcare providers, who have very little options of training in the South.

So, it's not that they're necessarily distinct, because there is this translation of ideas and people do move around, but I think the circumstances in which people get to practice are distinct and the structures that support the health systems are very different in the South. [They're] still really heavily segregated.

CHRISTOPHER BRICK: And then there's a transformation that happens that coincides with the civil rights movement. I think that's going to be... you know, we usually don't think of the civil rights movement as happening in medicine, but it does to a certain extent, right?

KYLIE SMITH: Right, it does. And I think people are usually very focused on education and that that's the main domain of civil rights and they're not necessarily as aware of what is happening in the

medical civil rights domain which, as you say, is really heavily segregated well into the 1960s.

And the Southern states were very hesitant- and I generalize when I say "the Southern states"- but some were very hesitant to desegregate. And in a way, medical practice and healthcare practice made it harder to integrate because of this belief about bodies and the intimate nature of healthcare work. And I really see that particularly in relation to nursing care and the absolute belief that Black women should not be laying hands on white people. So, that is a real source of tension for quite some time.

CHRISTOPHER BRICK: How does that get reconciled? You're talking about these disparities in terms of the training that's available to African American providers- it's pretty limited in the South. It's probably pretty limited everywhere, but *particularly* in the South, right. How are those lines policed and maintained when, as you say, there is so much intimacy inherent in healthcare provision?

KYLIE SMITH: You talked about separate and equal, right? So, there's a very strong policing of the separate-ness through the creation of separate facilities. Often out of mind, out of sight and I think that's definitely the case in psychiatry where you can literally have a place that is somewhere else. Psychiatric hospitals generally are not located in major cities, they are out in the rural areas- to some extent- because of the history of psychiatry generally. And then, when people want to segregate those facilities, they literally create a different place to put people.

CHRISTOPHER BRICK: Right, I think the "separate" part of it is very, very significant. It does seem like the disparity in investment we see in school systems also carries over into the psychiatric space, where the white facilities are much better funded and have better outcomes than the ones for the African American population. Were these real *dungeons*?

KYLIE SMITH: [*Laughing*] This is where the records are tricky because nobody is writing down; "Oh, we treat our patients really badly," so you need to be able to read between the lines a little. And thankfully, there were plenty of people who were not happy about conditions that were existing for African American patients, so I think about... newspaper exposés that were really fundamental in showing how bad it was for *everybody*. And often, the focus in those exposés was on white patients, like "This is terrible, the way we're treating our poor, white, disabled people." And then the subtext is; "If it's bad for white patients, it's *horrendous* for Black patients." And I do have evidence of, literally, Black patients in the basement. In buildings with substandard electricity, with no furniture, with people just being put in a large space...

CHRISTOPHER BRICK: Very inhumane, very inhumane. Was it understood to be inhumane? By which I mean to say that the inhumanity is part of the social control, it is part of the enforcement mechanism by which white supremacy is perpetrated and perpetuated?

KYLIE SMITH: I think there is a deliberate-ness to it, but also a lack of funding, generally. So, even in the 1950's when there's a very fierce segregation, superintendents will write about the

lack of funding and how they *cannot* build better services, or they can't improve conditions or employ more people because the state appropriation for mental health services generally is so small. And that is something that is specific to some of the key Southern states; this refusal for the state to spend money.

And then there is what I would call a... The inhumanity comes from the belief, I think, that African American patients are less human generally. This is where you see the transmission of ideas almost directly from the plantation; that African American people don't feel pain, that they don't get depressed, that they don't have a complex emotional system. And that "justifies" this lack of proactive and aggressive treatment.

CHRISTOPHER BRICK: You touch upon this briefly; the way that white supremacy itself is medicalized, is built into, not just the way these patients get described- get characterized, in clinical language- but the assumptions that these physicians and treatment professionals, clinicians, are carrying into that patient-provider relationship. And you talk about Samuel Cartwright as providing an early intellectual scaffolding for this medicalized construction of Black intellectual disability, inferiority, child-like simplicity, suggestibility. When is he writing that stuff? 'Cause it's earlier than the period you're describing, but it's still quite influential, right, over...

KYLIE SMITH: It is really interesting to me to see the fact that Cartwright wrote his *trash* in 1850's, for example. And then, I'm looking at a period that's 100 years later, and there are times when I feel like he could have written what I'm reading. It is really quite disconcerting at times when you

see white physicians continue to describe their Black patients in some of that same terminology. I don't mean that they are literally taking his ideas- I don't even... I doubt that any of them would have read him- but I do think that the ideas he espoused become so foundational to American psychiatric practice generally that they just become assumed norms. And it's very hard for physicians to break out of them.

I have a really interesting paper written in the late 1950's from a very intelligent psychiatrist who's talking about psychotherapy and its usefulness, or not, for Black patients. And he does this thing where he recognizes environmental trauma, recognizes the impact of the history of racism, and then will flip it so that it becomes a personal and moral failing rather than a structural issue. So, there is still this underlying assumption that somehow, Black patients are psychologically and emotionally different.

CHRISTOPHER BRICK: You have a particularly harrowing quotation passage that you quote verbatim in the lecture from Hal Watkins- am I pronouncing that correctly? Hal Watkins? Who refers to the compulsory labor imposed upon these patients, *required* of these patients, as tantamount to enslavement.

KYLIE SMITH: Yeah, I think it's really important to remember that these are institutions that are wholly staffed by white people. In all of the states that I'm looking at, they do not employ Black people- generally speaking- unless they're at the very lowest level of work.

So, when we talk about who is running these institutions, there might be a small amount of

white physicians and registered nurses and then majority of the people working in these places are untrained, underpaid, just local white people who they call attendants.

So, to think that you have people... and I don't mean that everyone in the South is bad and always has been [laughs] that's obviously not what I mean. But if you think about the 50's and 60's in Alabama, Mississippi, Georgia, you're looking at relations—social relations— that are really built on the idea that white people are superior and that the Black person needs to be kept in their space. To see violence used as a technique is not at all surprising to me, but it is— it is shocking. It happens in multiple places, and it happens through neglect, I think, but also the standard, "This is how we treat Black people."

CHRISTOPHER BRICK: There is this very serious barrier to these documents, to these records. How are you managing that and how are you finding it?

KYLIE SMITH: The records are a challenge, and they are also extremely interesting. I think about the usefulness, in particular, of court cases. That's really where a lot of the majority of the first kind of "open-my-eyes" type material, right, and from there I can work backwards and try and find better records. But, you know, I came at this story largely from a court case in Alabama in the late 1960s that was a very standard— I guess— civil rights case heard in the court of Judge Frank Johnson that exposed the conditions. He drew— in that court case— on a previous federal government inspection and so those records are hard to come by. The federal department that undertook that inspection seems to have disappeared. Those records

are not in the National Archives, which is kind of interesting.

CHRISTOPHER BRICK: What was the agency?

KYLIE SMITH: It's the Office of Equal Health Opportunity. It was part of Health, Education, and Welfare.

CHRISTOPHER BRICK: And they're just gone?

KYLIE SMITH: Well, the archivist says, "We don't have a listing under that particular name. We think that once the work of that office was done, it was dissolved and the records gone." So, I spent a long week in the National Archives trying to come at that from various different angles and we did discover that there are some boxes that might have what we're looking for, that are restricted and so I've had to submit a Freedom of Information request.

CHRISTOPHER BRICK: They're restricted because of HIPPA?

KYLIE SMITH: Possibly. I think that is part of the difficulty of when you're looking at trying to uncover conditions in hospitals— especially psychiatric hospitals. Current legislation around patient privacy has put an automatic kind of stop on accessibility of those records.

Even when I personally might have an IRB ruling or I'll sign a statement that says I promise to be ethical and to not use patients' names, there is a lot of fear. And, also, because I am dealing with a more recent period, the reality is that some of the people who I'm writing about— even without knowing their names— may be still alive or have family who

are alive. So HIPPA has made that more difficult, and archives are much more protective.

I've been in the state archives here in Georgia where I just wanted to get a sense of how the Community Mental Health Act meant that patients were moved, and I had no interest in, actually, names, I just wanted the data, but I couldn't look at those files because they have patients' names in them. And they haven't been redacted because it's low priority for archives to make those records accessible.

CHRISTOPHER BRICK: I really sympathize with and appreciate the work you're doing to try to get access to this. And I wonder sometimes if there should be some kind of historian exception for HIPPA, you know, past a certain time horizon. Because I know even going much further back than the period you're working in, it can be really impossible to access records that otherwise just sit there.

KYLIE SMITH: Yeah! I mean, I think as historians we know not to use peoples' names, right? And so, it would be really easy to make information available to us that we... at least sign some sort of contract where we absolutely said we would not use names even if we came across them. But the fact that there are names sometimes means you don't even get to look at them before they're snatched out from underneath you!

CHRISTOPHER BRICK: You mentioned that as well, that you have been in research room situations where the archivists... You're delivered records and then they're repossessed because of privacy concerns after the fact.

KYLIE SMITH: And again, this is because of neglect in the archives— not because of the archivists' fault, but just a prioritizing in how they spend their money. Especially here in the South where a lot of the money on digitization, etcetera, or archival maintenance gets spent on Civil War, making sure that people have access to family records and stuff. That's all kind of important, but medical or institutional records are not high on their list of priorities.

So, I was sitting there, at the Georgia Archives, and I had called up some boxes that I think no one had really ever looked at, and they were related to the administration of the State Department of Mental Health. They happened to have patient files in there in relation to transfer of patients— so moving people from one facility to another— and the archivist saw that there was a little red asterisks on the box and she came over and was like, "Oh, no, you can't look at those." And she just took the box back off me, so I didn't even really get to look at what else was in the box.

CHRISTOPHER BRICK: Frustrating... incredibly frustrating.

KYLIE SMITH: Yeah, sometimes.

CHRISTOPHER BRICK: You talk about the way that the language changes and evolves, in some ways, to camouflage the maintenance of white supremacy notwithstanding these mandates that are coming down from the federal courts and from— I guess post-1964— the Justice Department. Could you talk a little bit more about those? Because that sounds terribly interesting.

KYLIE SMITH: Yeah, there is this really interesting moment, I think, where the mandate from the courts around integration leads to a kind of obfuscation of racial data. So, one way to not have to demonstrate whether you're integrated or not, is to just not collect the data. So, there's this kind of shift in the records where previously, before 1963, I have really great data that is very clearly categorized along racial lines and this relates to, say, diagnostic criteria.

So, I'll have a table that says "these are how many we've diagnosed with schizophrenia, these are the men, these are the women, these are the Black men, these are the Black women." That stops from about 1963/1964, because of this, you know, awareness that there's gonna be money available, that it will rely on a facility being racially integrated, so if you're not collecting the data, you can't really be brought to task. There is this, kind of- I would say a deliberate- obfuscation and then a de facto; "Let's just not."

CHRISTOPHER BRICK: Right, because it's not as if just because the law is evolving, that attitudes are. They're not, right?

KYLIE SMITH: Right, they don't change overnight. There are plenty of people who don't believe that racial segregation is necessary in medical or psychiatric facilities, and they do argue that there is no racial difference. So, they're saying that you don't necessarily need to classify people along racial lines, and yet the disparities still exist. It's really complicated, the way language changes from this, "Let's move away from race-based diagnosis," to then, how that actually hides the continuation of segregation.

CHRISTOPHER BRICK: Yeah, and that's only going to be harder for you to track given the inaccessibility issues that we were talking about. So, there really is quite a bit of work left to be done in this area.

KYLIE SMITH: Absolutely. I find it later in the records, even. I happened to have come across a court case from the late 1970s related to children, and I'm not sure what I'm going to do with this yet. And it happens to have patient's records in the court case, so they're submitted into evidence, so they're publicly available. They have been redacted, so I can use them. And they show a very clear difference in the way that racial language is used, and the changing terminology, and it's really interesting to see some of the more remote hospitals— or facilities— talk about "Blackness." And they'll use that word, or they'll still use "Negro," even in the 1970's! But some are shifting towards this terminology of "non-white" so white and non-white. So, non-white becomes this catch-all category. So, it is complicated.

And it's a very complicated moment in the history of psychiatry generally, I think; the late 50s and early 1960s. Because you have multiple factors that are transforming the way that psychiatry is done, and places and spaces in which it's done. And so, you have drugs from the 1950s, like Thorazine in particular, that can be used inside institutions to calm people and make a large facility— some of these facilities... The one in Georgia has 12,000 people in it— so drugs that help make an institution that size run smoothly are used in the system and are very welcome there. *How* they're used is a whole other story.

From the 1960's, you have the move to community-based mental health, and so it's made possible because of those drugs; the belief that you can have people out in the community and have them be contained and calm, and not causing harm to themselves or others. But it is also overlaid with an ideology about the legality of confinement and the advent of a patients' rights movement— which also overlaps with civil rights. So, it is a really complicated moment. Then you have Medicare and Medicaid that come along in 1965, which changes the funding model again.

CHRISTOPHER BRICK: Right, because that also creates this whole... On the one hand, this pipeline of federal money, but there's also a lot of strings attached to that federal money and so those institutions are trying to be responsive to that as well. It's not that different from what we see with Obamacare, I guess, later on, right?

KYLIE SMITH: It's a very similar situation. You see a lot of the same resistance, that "Let's not take too much of that federal funding because we don't want to be told what to do." And that's definitely what—

CHRISTOPHER BRICK: "Because we don't like the strings that are attached!"

KYLIE SMITH: Right. You know, in that court case in Alabama, the Attorney General says, "Here is the federal government getting its nose under the tent like a camel." [*Laughing*]

Anti-federalism. And whether that's an actual rhetorical device or a real political strategy is also difficult to unpack. I have spoken to a psychiatrist and a lawyer in Alabama at the moment,

who's bringing a lot of prison court cases, right—because we see the replication of these problems in the prison system— and I said, “Is it just because they don't want to spend money? Is that what it's about? Is it still racism?” And he said, “Yeah, they just don't want to spend money on *those* people.”

CHRISTOPHER BRICK: Or, at least, if they are spending money on those people, it's to implant them in these carceral networks where the degree of social control is even *that* much more extreme.

I'm glad you brought that up, because you do have a place in the talk where you talk about the interconnection between the public health infrastructure that's committed to psychiatric treatment versus the carceral networks that are in place in these localities. I couldn't help but think of *Madness in Civilization*, right, *Discipline and Punish*. It does feel like there's quite a bit of Foucauldian stuff going on in the talk. Those frameworks are important, right, to the work that you're doing?

KYLIE SMITH: Absolutely, I defy anyone who's doing the history of psychiatry to have not read Foucault and “everything is a prison.” I do have that point of view, generally speaking. That is my position, is that I am anti-confinement. And I've read my Foucault; I have a whole stack of books over there.

CHRISTOPHER BRICK: All the best people do, right?

KYLIE SMITH: [*Laughing*] Right. And I don't think there's any point in trying to hide that. I think that Foucault himself is, to some extent, a historian of psychiatric practices, and so he's part of our “genealogy”— to use his own term. But

you do see it; it's really hard not to see the way that these institutions are operating- especially in the South, but it's true everywhere- but you see this almost directness about it in the South in a way that I haven't seen elsewhere to the same extent, in terms of how it's even articulated.

When the big hospitals start to close down in the early 1970's, there is a conversation in Alabama in particular between the chief of police in Birmingham and the super intendent of the hospital saying, "What am I meant to do with these people that are turning up on my doorstep?" So, when you release 4,000 people from a hospital and you *don't* have adequate community-based services in place for them, it's almost inevitable that they will end up in the carceral system.

CHRISTOPHER BRICK: There's recidivism, right.

KYLIE SMITH: And whether that's deliberate or not, we could debate that. It does feel inevitable in a way because people are scared, right? People are scared of the mentally ill. There aren't support services. Families aren't supported, and so people are left homeless and with no job skills.

I think that there is a disparity in terms of service provision that is historical. So, where areas are more likely to be communities of color, they are less likely to have local services available. Then there is, unfortunately, a very strong- what has been called a- diagnostic apartheid; a really quite severe disparity in diagnostic criteria that particularly badly affects... I was going to say young people [of color], but it's all people of color that really draws on these long historical attitudes about the difference. Like, "Oh, they just don't get

depressed," or "African Americans are more likely to be schizophrenic," and so that's how they're more likely to be diagnosed.

CHRISTOPHER BRICK: You're in a nursing school you said, right? Are there historian jobs in nursing schools or is there one of you?

KYLIE SMITH: [*Laughing*] I think there's, like, two of us. Nursing and health sciences generally in the United States are very driven by NIH funding, very heavily, you know, bench sciences; science is the thing. And that is true of most schools of nursing; they're driven by metrics that are about research money from the NIH. Historians don't get money from the NIH, but I'm very fortunate that there are other places in the United States that support humanistic inquiry and make that connection between the humanities and the health professions. So I'm part of a Mellon Foundation program that is specific to Emory that deliberately sought to bring the humanities into the health professions. So, there's one of me in public health, there's one in law— interestingly not one in the school of medicine but the school of nursing saw the need for a historian. And not just a historian that would document nursing but would do exactly what you're talking about; really try and bring the humanities to bear on really complicated social problems.

CHRISTOPHER BRICK: Maybe this podcast can help bring more of those two spaces together?

KYLIE SMITH: Right. I think that any university that has a school of nursing, public health, [or] medicine should have a historian in those schools. I think especially if you're committed— or say you're committed— to issues of disparities and social justice, then you can't do that from a

science point of view. You really need someone to help unpack the root causes and that requires a historian.

CHRISTOPHER BRICK: Yeah. I mean, even if you just talk about... You, as a historian, have to submit to IRB reviews and things like that, right? Because you're working with medical records and so that implicates the medical ethics and human-subject ethics side of the equation. That itself implies humanistic inquiry and evaluation, you know? You can't consign any of those reviews... that process just to the science side alone.

KYLIE SMITH: It is funny though. I have put in an IRB for my new project, and I was politely told that it wasn't conceded research... like, what? The ability of the sciences to speak to the humanities is still a big language barrier.

CHRISTOPHER BRICK: Yeah. I find there's also just a conceptual barrier, the way that people understand it. I mean, if you talk to policy makers here in Washington, they *completely* get the value of investing in science. It produces technology that can be "marketed." I mean, there's all these... You kind of don't really have to persuade them that there's value in public investment and creating public goods around scientific work.

Humanistic work? Different story. [Laughs] They really need to be hand-held into that, and I've had those conversations! I mean, I've tried to be a voice for the history community and funding of the historical humanities in the policy space. And I run into this all the time!

KYLIE SMITH: It is really interesting, that value. How do you measure the value and are you measuring

it in terms of immediate grant funding, or are you really willing to measure the value of the humanities in terms of long-term system change? And I think a lot of people don't want that. They don't really want the system to change. It's benefitting a lot of people the way it is, generating millions of dollars that goes into elevating a school's ranking.

CHRISTOPHER BRICK: Yeah, there's a lot of inertia attached to that, for sure.

KYLIE SMITH: I think it's changing thought. I was really thrilled lately to be asked to present my work as a Grand Rounds for Emory psychiatry. Grand Rounds are usually clinical, so they'll take a clinical case and pull it apart. To be invited as a historian to give a Grand Rounds presentation to a bunch of psychiatrists on a historical project was incredibly... really rewarding. And the feedback I got was overwhelmingly supportive.

CHRISTOPHER BRICK: When I was a younger person, 20/25 years ago, there did seem to be this big divergence going on in the field. There were "history of science" people that were carving out this separatist niche within the profession and then, in some cases, building entirely separate departments in some places. "History of medicine" was sort of in the same boat. Was that a good judgment call?

KYLIE SMITH: Disciplinary boundaries are always problematic, I think, and I do feel them as a trained historian working in a clinical school that is quite siloed from the rest of the academic enterprise at a big university that has a liberal arts core. It has taken a good four or five years to break down some of those disciplinary barriers.

And part of it is this history of the specialization of knowledge, right? And who gets to speak for that discipline.

Yeah, it's an interesting question about how do we find ways to just be historians and to bring historical work to bear on contemporary problems.

CHRISTOPHER BRICK: I mean I... It seemed illogical to me at the time; I'll just put my cards on the table about this. I mean, if you study the history of science, does that implicate a methodological approach that is so different as to warrant separate institutional walls?

KYLIE SMITH: I think the silos tend to assume somehow that medicine or science or nursing or public health are not part of society! That they're somehow separate. But, in fact, they're an integral part of the way we live and an integral part of the way that American society in particular is structured. And so, they are complex historical problems, not just "history of medicine" problems.

CHRISTOPHER BRICK: And, before we wrap, I just... I wanted to ask what's going on with you? I mean, this is your project right now, this is what you're working on right now. It's a book that you're doing, yeah?

KYLIE SMITH: Yeah, I'm very fortunate. I was awarded the National Library of Medicine grant for scholarly works in biomedicine.

CHRISTOPHER BRICK: Well done, well done!

KYLIE SMITH: I was so excited to get that last year. So that has facilitated extensive archival work and I am very excited that the project is under contract with UNC, the University of North

Carolina Press. And we're even more excited because we're perusing an open-access publishing route. So, it will be a book that you can buy and read off a shelf, but we're also developing it as an open-access digital humanities project, so people will be able to read the same book online. And then also have an enhanced experience because I'm interviewing people and we're doing a whole heap of cool digital stuff so that people can really participate in this project in a real public-facing kind of way.

CHRISTOPHER BRICK: Alright, so, listeners; be on the lookout for Kylie's next work and, and in the meanwhile, you also should all go follow her on Twitter right now because your Twitter feed is one of my favorites.

KYLIE SMITH: Thank you!

CHRISTOPHER BRICK: I don't say that just because we're chatting right now.

KYLIE SMITH: It's the dog pictures, isn't it?
[Laughing]

CHRISTOPHER BRICK: Well, and you know, you had those beautiful photos of the beach in Australia and your lunches and knitting. You're a knitter?

KYLIE SMITH: Yes, I knit so I don't kill people!

CHRISTOPHER BRICK: Yeah, that's kind of an anxiety-management tool, right, knitting? Everybody that I know knits really uses it to clarify their own headspace.

KYLIE SMITH: It's really great. It's just really great to be out of my head and just doing something with my hands and not thinking. I think for me...

People often say to me, you know, "How do you cope?" because the archival stuff is really rough sometimes and I'm like, "I'm okay. I just go home and knit."

CHRISTOPHER BRICK: [*Laughing*] I can put that on my list for 2021. 'Cause I did have friends that took up knitting during the pandemic. One in particular hired somebody to teach him and everything.

KYLIE SMITH: Awesome! That's wonderful.

CHRISTOPHER BRICK: Yeah, he just loves it. He's not made me socks or anything yet, but...

KYLIE SMITH: I'd get on that.

CHRISTOPHER BRICK: Yeah. Kylie Smith, this was so wonderful.

KYLIE SMITH: Great.

Conclusion

CHRISTOPHER BRICK: And that's a wrap. Please join us again next time for "Dirty Discrimination: Sanitation and Civil Rights Protest in New York, 1962-1970." I never knew so much about the interconnection between sanitation policy, the New York City Department of Sanitation, and the civil rights movement of the 1960s and 1970s until listening to Tina Peabody's wonderful talk. Don't miss it. We'll catch you next time.