Eugenics is having a quiet revival—
and medicine must respond

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Eugenics is often remembered as a discrete historical episode: a pseudoscientific movement culminating in forced sterilizations, immigration quotas, and the atrocities of Nazi racial policy. That framing is both correct and misleading. Correct, because it confines eugenics to a morally quarantined past; misleading, because the underlying logic—ranking human worth according to perceived biological or social fitness—has never fully disappeared.[1] It simply evolved. And in ways both subtle and overt, it is slipping back into our public conversations, our health policies, and our assumptions about whose lives are worth protecting.

Eugenic foundations

In this essay, I use *eugenic thinking* to mean any ideology or policy that explicitly or implicitly assigns differential value to human lives based on heritable traits, disability, race, ethnicity, or socially constructed hierarchies of "fitness," and that translates those judgments into regulated advantage or disadvantage. This definition distinguishes eugenics from prejudice or bigotry alone. Bigotry is attitudinal; eugenics becomes operative when such hierarchies are encoded in science, law, or policy and justified as rational, natural, or beneficial to the population.

The American eugenics movement did not emerge in isolation, nor did it vanish abruptly after World War II. Its intellectual roots lay in late nineteenth-century Social Darwinism, when evolutionary theory was misapplied to social hierarchy and a wide range of social differences were pathologized and attributed to flawed heredity rather than to systemic or environmental factors. Poverty, mental illness, intellectual disability, epilepsy, criminality, alcoholism, "sexual deviance," and especially race and immigrant status were identified as markers of biological inferiority.

After the horrors of Nazi racial policy discredited overt eugenics, the language shifted. "Race betterment" receded, but concerns about population quality, dependency, and demographic change persisted in subtler forms. The postwar emphasis on civil rights did not eliminate hierarchies of worth; it rendered them less explicit. Understanding this continuity is essential. The risk today is not a return to sterilization statutes, but the reappearance of sorting logics under new scientific or economic rationales.

The pendulum of medical ethics does not swing arbitrarily. It swings between inclusion and exclusion, between protection of the vulnerable and rationalization of inequality. When science is recruited to justify exclusion—whether overtly or through omission—medicine becomes vulnerable to repeating old mistakes in new forms.

This is not an argument that contemporary America replicates the early 1900s, nor that every flawed population-level policy is eugenic. Rather, it is a call for conceptual clarity and professional vigilance. The danger

today is not overt state-mandated sterilization. It is the normalization of stratified protection, selective empathy, and biologized narratives of worth that quietly shape public health, immigration, reproductive policy, and emerging genetic technologies.

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Historical context

American eugenics was neither fringe nor accidental. As Daniel Okrent documents in *The Guarded Gate*, leading academics, philanthropists, and physicians advanced the claim that certain European immigrants—Jews, Italians, Slavs—were biologically inferior and socially corrosive.[2] Figures such as Madison Grant, a conservationist and author of *The Passing of the Great Race,* and Henry Fairfield Osborn, president of the American Museum of Natural History, lent scientific authority to nativist ideology. Their work influenced the Immigration Act of 1924 (Johnson–Reed Act), which dramatically restricted immigration from Southern and Eastern Europe and excluded Asians entirely, effectively delaying the entry of unwanted groups into the US for more than 40 years.

Between 1907 and 1979, more than 60,000 people in the United States were forcibly sterilized under state eugenic laws, with California alone accounting for roughly one-third of those procedures.[3] Although both men and women were sterilized, women—particularly those labeled "feebleminded," poor, disabled, or socially deviant—were disproportionately targeted. Racial minorities, including Black, Latina, and Native American women, were also overrepresented relative to their population size, reflecting how eugenic ideology intersected with poverty, racism, and gender bias.

These programs received constitutional sanction in *Buck v. Bell* (1927), when the US Supreme Court upheld Virginia's sterilization statute. Writing for the majority, Justice Oliver Wendell Holmes, Jr. declared, "Three generations of imbeciles are enough," referring to Carrie Buck, her mother Emma Buck, and her infant daughter Vivian—three women whom the Court accepted, without meaningful scrutiny or objective evidence of intellectual impairment.[4] The decision legitimized coercive sterilization nationwide and remains one of the starkest examples of how medical and legal authority can converge to codify hierarchy in the name of public welfare. (The decision still stands today.)

These policies were not enacted in the language of hatred. They were outlined and implemented as stewardship, improvement, and prudence. Eugenics provided what Okrent described as a veneer of inevitability—biology, not bigotry.[2]

It is important to draw a careful line here. Not every restrictive immigration or public health policy is eugenic, nor is every instance of xenophobic rhetoric evidence of biological ideology. Policy can be driven by economic concerns, security fears, or political calculation. What transforms exclusion into something more closely resembling eugenics is the invocation—explicit or implicit—of biological or demographic threat narratives: claims that certain groups degrade the national stock, weaken collective vitality, or imperil civilizational survival. When arguments shift from resource management to hereditary or civilizational fitness, medicine must be alert to how scientific language may again be recruited to legitimize hierarchy.

This history underscores a crucial distinction: eugenics becomes most dangerous when embedded in institutional authority—medicine, law, or public health—not merely in private prejudice.

Immigration policy

Contemporary immigration rhetoric occasionally echoes early twentieth-century language that cast certain groups as threats to national vitality. Recent statements referring to immigrants from particular regions as undesirable or inferior have drawn historical comparisons.[5] While rhetoric alone does not constitute eugenics, immigration policies that systematically restrict entry based on ethnic or national origin, justified by claims of cultural or biological incompatibility, bear conceptual resemblance to earlier eugenic frameworks.

It is important to differentiate stigmatizing categorizations from eugenic classifications. Prejudice or xenophobia may arise from fear or ignorance. Eugenics emerges when those attitudes are rationalized through appeals to biology, demography, or suitability, and codified into durable policy structures.

American history provides sobering examples beyond the 1920s. The limited US response to Jewish refugees during World War II—despite knowledge of Nazi persecution—reflected nativist and demographic anxieties that paralleled earlier eugenic-inflected immigration restriction. Likewise, the long history of displacement and coercive assimilation of Native Americans reflects hierarchies of civilizational and racial worth. These were not always labeled "eugenics," but they operated within similar hierarchies of human valuation.

The lesson is not that the present uniquely surpasses the past in moral failure. Rather, exclusionary reasoning has recurred across administrations and eras. Medicine must avoid lending scientific legitimacy to such hierarchies, regardless of political context or persuasion.

Vaccines

Linking vaccine hesitancy to eugenics is a recent development.[6] Clearly, personal refusal differs from state-imposed sorting. However, when public policy narrows universal protections in ways that predictably disadvantage vulnerable populations, structural concerns arise.

For example, until recently, universal newborn hepatitis B vaccination was recommended by the CDC and functioned as an equity tool. Hepatitis B can be transmitted perinatally, and maternal screening is not infallible. Universal vaccination reduces disparities and strengthens herd immunity. When universal recommendations are narrowed to "risk-based" criteria, gaps in screening, access, and follow-up disproportionately affect socioeconomically vulnerable populations. Reduced herd immunity also increases community risk, as illustrated by recent measles outbreaks in underimmunized regions.

This is not equivalent to forced sterilization. But public policy can normalize differential protection. When preventable disease clusters in marginalized communities due to predictable access gaps, we must ask whether equity was adequately considered in policy design.

There is also an ethical distinction between intentional harm and foreseeable disparate impact. Classic eugenics was forcible and explicit. Contemporary policies may arise without malicious intent. Yet medicine has long recognized that foreseeable harm carries moral weight even when intent is benign. Public health decisions that predictably widen disparities require ethical scrutiny regardless of motive. The question is not whether policymakers harbor eugenic aims, but whether the consequences of their decisions disproportionately burden those already vulnerable. Ethical vigilance demands attention to outcomes as well as intentions.

During COVID-19, narratives that minimized deaths among the elderly or those with comorbidities revealed implicit hierarchies of worth. Differential mortality by race and socioeconomic status was well-documented.[7] The ethical failure lay not in individual choice alone, but in inconsistent public messaging and insufficient protection for high-risk workers and communities. When preventable suffering becomes socially tolerable because it affects "only" certain groups, medicine must react to protect those groups.

Academic and institutional reckonings

As shown in Table 1, many universities have publicly examined historical ties to eugenic research and funding. Responses have included formal apologies, commissioned historical reports, removal or renaming of buildings, curricular reforms, and public memorialization of victims. In the case of UC Berkeley School of Public Health, funds earmarked for a eugenic research fund were repurposed toward equity initiatives.[8]

Major philanthropic institutions also played a significant role in legitimizing and financing the American eugenics movement. The Carnegie Institution of Washington funded the Eugenics Record Office at Cold Spring Harbor from 1910 until 1939, supporting research that sought to document and classify hereditary "defects" and that influenced immigration restriction and sterilization policies. The Rockefeller Foundation likewise provided grants for early twentieth-century genetic and racial research, including projects that intersected with eugenic theory in the US and abroad. Although both institutions later distanced themselves from eugenic ideology—Carnegie ultimately withdrawing support after concluding the work lacked scientific merit—their early funding helped embed eugenic ideas within mainstream scientific and policy discourse.

Such reckonings do not erase institutional history, but they represent efforts to align present values with a more candid accounting of the past. They reflect an important professional responsibility: transparency. Acknowledging entanglement does not indict modern science wholesale. It strengthens credibility by demonstrating moral continuity and institutional humility.

The new frontier

The most consequential ethical terrain lies ahead.[9] Advances in genome editing (CRISPR-Cas9), germline modification, polygenic embryo screening (PGT-P), and in vitro gametogenesis promise reduction of severe genetic disease. They also raise classic eugenic questions: Who decides which traits are undesirable? What constitutes disease versus difference? How are disability communities represented in these decisions?

To acknowledge these issues is not to reject genetic medicine. Newborn screening programs have prevented suffering for decades. Carrier testing allows informed reproductive decisions. Targeted gene therapies now offer hope for previously untreatable diseases. The ethical fulcrum lies in purpose and proportionality. Therapy seeks to alleviate clearly defined pathology. Enhancement seeks optimization according to socially constructed norms of desirability and performance rather than clearly defined medical need. When the boundary blurs, medicine risks reintroducing value judgments about which lives are preferable.

The disability community has, for decades, warned that the pursuit of genetic "cures" and the elimination of specific conditions (such as Down syndrome, deafness, or dwarfism) can be experienced as a form of "new eugenics" or "genetic genocide."[10] This perspective stems from the belief that when society focuses on eliminating a condition, it simultaneously devalues, stigmatizes, and expresses a desire to eliminate the persons who currently live with that condition. Ethical deliberation must therefore focus on removing societal barriers rather than "fixing" the individual, and include those most directly affected by definitions of normalcy.

Polygenic embryo screening, already marketed in the United States, selects embryos based on probabilistic scores for complex traits.[11] While framed as disease prevention, critics note limited predictive power, potential reinforcement of ableist norms, and socioeconomic stratification if access is restricted to affluent families.

Germline editing has irreversible, heritable effects that raise profound ethical, social, and safety concerns, prompting many nations to impose moratoria or strict regulations.[12,13] The UK's Human Fertilisation and Embryology Authority licenses research on human embryos but prohibits clinical use, while Germany and France have statutory prohibitions on germline modification. These policies reflect a deliberate choice to prioritize ethics and safety over technological capability, demonstrating that capacity does not compel permissibility.

The ethical distinction between therapy and enhancement is not trivial. Treating cystic fibrosis differs morally from selecting for height or intelligence. Once enhancement becomes normalized, social pressure may replace overt coercion. Markets can sort as effectively as states; vigilance is therefore required in both public and private sectors.

Medicine's responsibility in this moment

Newborn screening, carrier testing, and targeted therapies have alleviated suffering and extended life. The ethical challenge is not genetic knowledge itself, but its framing and distribution. Genetic science becomes eugenic when it shifts from alleviating suffering to optimizing populations according to socially contingent ideals.

Concerns about human performance enhancement in sports or military contexts illustrate this tension. Enhancement research, detached from equity safeguards, can normalize biologized competition and exacerbate inequalities. Regulation, transparency, and broad public deliberation are therefore essential.

Eugenics does not thrive merely because individuals harbor prejudice. It thrives when institutions fail to interrogate how policies distribute protection and risk.

Physicians can:

1. **Interrogate policy through an equity lens.** Ask which populations bear disproportionate burdens under new policies.
2. **Reject biological essentialism.** Reinforce that race is a social construct with limited genetic correlation and avoid reifying race in clinical algorithms without justification.
3. **Support universal public health measures** when evidence shows they reduce disparities.
4. **Advocate for robust oversight of reproductive technologies,** including nondirective genetic counseling and equitable access safeguards.
5. **Educate trainees** about the history of American eugenics, including forced sterilization and immigration restriction.
6. **Engage publicly.** Silence can imply acquiescence when pseudoscience enters policy discourse.
7. **Center disability voices** in conversations about screening and selection.

Medicine's authority confers responsibility. Our profession once legitimized forced sterilization. It later helped dismantle those laws. The question is not whether humanity can eliminate prejudice entirely; history suggests otherwise. The question is whether medicine will lend its credibility to hierarchies of presumed worth—or resist them.

> *The moral trajectory of medicine depends not on historical determinism, but on whether clinicians are willing to examine the assumptions embedded in emerging science and policy.*

Eugenics rarely returns wearing its original uniform. It reappears as optimization, efficiency, or prudence. The measure of our profession will not be technological sophistication, but moral clarity.

There is reason for guarded hope. Organized medicine has, at times, corrected its course. The same profession that once endorsed sterilization laws later helped expose their injustice. Institutional review boards, bioethics scholarship, disability advocacy, and civil rights law have reshaped medical decision-making over the past half century. Progress has never been linear, but neither has regression been inevitable. The moral trajectory of medicine depends not on historical determinism, but on whether clinicians are willing to examine the assumptions embedded in emerging science and policy. Professional silence, not technological innovation, poses the greater risk—and we cannot afford to look away.

References

1. Kevles DJ. *In the Name of Eugenics: Genetics and the uses of human heredity.* Cambridge, MA: Harvard University Press;1998.
2. Okrent D. *The guarded gate.* New York, NY: Scribner; 2019.
3. Stern AM, Novak NL, Lira N, O'Connor K, Harlow S, Kardia S. California's sterilization survivors: an estimate and call for redress. *Am J Public Health.* 2017;107(1):50–4. doi: 10.2105/AJPH.2016.303489. Epub 2016 Nov 17. PMID: 27854540; PMCID: PMC5308144.
4. Cohen A. *Imbeciles: The Supreme Court, American eugenics, and the sterilization of Carrie Buck.* New York, NY: Penguin; 2017.
5. McManus D. Trump's latest anti-immigrating push echoes the nativism of the 1920s. *Washington Post.* December 9, 2025. Accessed February 13, 2026. https://www.washingtonpost.com/politics/2025/12/07/trump-immigration-somalis-afghan-crime/
6. Schwartzman R. Vaccination in the shadows of eugenics. In: *Pandemic resilience: vaccination resistance and hesitance, lessons from COVID-19.* Berube DM (ed). Springer; 2024:17–27. doi: 10.1007/978-3-031-74062-6_2
7. Magesh S, John D, Li WT, Li Y, Mattingly-App A, Jain S, Chang EY, Ongkeko WM. Disparities in COVID-19 outcomes by race, ethnicity, and socioeconomic status: A systematic-review and meta-analysis. *JAMA Netw Open.* 2021;4(11):e2134147. doi: 10.1001/jamanetworkopen.2021.34147. Erratum in: JAMA Netw Open. 2021 Dec 1;4(12):e2144237. doi: 10.1001/jamanetworkopen.2021.44237. Erratum in: *JAMA Netw Open.* 2022 Feb 1;5(2):e222170. doi: 10.1001/jamanetworkopen.2022.2170. PMID: 34762110; PMCID: PMC8586903.
8. Lombardo PA. Legacies of eugenics: an introduction. *Los Angeles Review of Books.* Published online. Accessed February 13, 2026. https://lareviewofbooks.org/article/legacies-of-eugenics-an-introduction/
9. van Dijke I, Lakeman P, Mathijssen IB, Goddijn M, Cornel MC, Henneman L. How will new genetic technologies, such as gene editing, change reproductive decision-making? Views of high-risk couples. *Eur J Hum Genet.* 2021;29(1):39–50. doi: 10.1038/s41431-020-00706-8. Epub 2020 Aug 9. PMID: 32773775; PMCID: PMC7852899.
10. Miller PS, Levine RL. Avoiding genetic genocide: understanding good intentions and eugenics in the complex dialogue between the medical and disability communities. *Genet Med.* 2013;15(2):95–102. doi: 10.1038/gim.2012.102. Epub 2012 Aug 16. PMID: 22899092; PMCID: PMC3566260.
11. Visscher PM, Gyngell C, Yengo L, Savulescu J. Heritable polygenic editing: the next frontier in genomic medicine? *Nature.* 2025;637(8046):637–45. doi:10.1038/s41586-024-08300-4.
12. Doudna JA. The promise and challenge of therapeutic genome editing. *Nature.* 2020; 578(7794):229–36. doi: 10.1038/s41586-020-1978-5. Epub 2020 Feb 12. PMID: 32051598; PMCID: PMC8992613.
13. Howard HC, van El CG, Forzano F, Radojkovic D, Rial-Sebbag E, de Wert G, Borry P, Cornel MC; Public and Professional Policy Committee of the European Society of Human Genetics. One small edit for humans, one giant edit for humankind? Points and questions to consider for a responsible way forward for gene editing in humans. *Eur J Hum Genet.* 2018;26(1):1–11. doi:10.1038/s41431-017-0024-z.

Table 1. Universities examining or addressing eugenics entanglements

University	Historical connection to eugenics	Institutional response/ corrective actions	Nature of action
Stanford University	Former president David Starr Jordan was a leading American eugenicist; affiliated with the Eugenics Record Office and sterilization advocacy.	Renamed Jordan Hall and other campus sites; initiated faculty-led historical review; engaged in public dialogue about legacy.	Renaming; public acknowledgment; historical review.
Indiana University Bloomington	David Starr Jordan previously served as president; Indiana passed the first US sterilization law (1907).	Board of Trustees voted to remove Jordan's name from Jordan Hall, parking garage, and Jordan River.	Renaming; institutional statement affirming inclusivity.
University of Virginia	Faculty members supported Virginia's 1924 Racial Integrity Act; involvement in state eugenics policies.	Formal public apology; historical report; memorialization of victims; curricular inclusion of eugenics history.	Official apology; educational reform; commemorative efforts.
University of Vermont	Faculty involvement in state-sponsored Eugenics Survey of Vermont promoting sterilization.	Issued formal apology (2019); commissioned historical report; launched community reparative initiatives.	Apology; institutional research report; reparative programming.
University of Minnesota	Early twentieth-century researchers contributed to intelligence testing and eugenic scholarship; university president expressed segregationist views.	Public examination of archival records; academic symposia; curricular reflection.	Historical review; public acknowledgment; educational programming.
Harvard University	Faculty promoted scientific racism and eugenics (e.g., Louis Agassiz; Charles Davenport affiliations; Holmes family legacy).	Removal of portraits and honors in some cases; ongoing faculty and student calls for renaming societies; public statements recognizing history.	Selective renaming; acknowledgment; ongoing debate.
Yale University	Faculty involvement in eugenic research and organizations in early twentieth century.	Institutional historical investigations; reassessment of named spaces; diversity and inclusion initiatives.	Historical inquiry; policy review.
University of California, Berkeley	Managed the Genealogical Eugenic Institute Fund; faculty involvement in eugenics-related research.	Froze and reviewed fund; public acknowledgment by leadership; contextualized historical role.	Fund review; public acknowledgment; ethical reassessment.
University of Southern California	Building named after Rufus von KleinSmid, eugenics supporter.	Removed his name from Center for International and Public Affairs building (2020).	Renaming; public statement.
University of Pittsburgh	Graduate School of Public Health named after Thomas Parran, who oversaw Tuskegee and Guatemala syphilis experiments.	Removed Parran's name (2018) following faculty and student advocacy.	Renaming; institutional repudiation.
University of Alabama	Honors building named after Josiah C. Nott, polygenist; promoted racial inferiority theory.	Ongoing public debate; academic projects (e.g., Hallowed Grounds Project) documenting legacy.	Public scholarship; continued renaming debate (no full removal yet).
Columbia University	Dorm named after Samuel Bard, slaveholder and early medical school founder; historical ties to scientific racism.	Renamed dormitory; public statement acknowledging legacy.	Renaming; institutional acknowledgment.