

v. Comparing Specialty Choices

PROBLEM

IT WAS A MAJOR HOPE and expectation that the increased enrollment of minority students in U.S. medical schools would to some extent correct both the geographic and specialty maldistribution of physician manpower in this country. Specifically, federal health manpower, legislation, Public Law 94-484, provided financial aid incentives for newly graduated physicians to pursue careers in primary care medical specialties, and to locate in federally designated areas of physician shortage. Similar financial incentives also were directed at all medical center residency training programs, which were required to contribute increasing percentages of their trainees to the national pool of primary care physicians.

Historically, almost 85 percent of all minority physicians have graduated from the two predominantly Black medical schools, Howard and Meharry, having been excluded from other schools by a process either of de facto or de jure racial discrimination. It was not until after World War II that Blacks had any real opportunity to pursue postgraduate medical specialty training. In 1947 only 93 of the 4,000 known U.S. Black physicians were certified by any specialty board; by 1957, the number of specialists had risen to 320, and in 1969, 1,074 of the 6,000 Black physicians were board-certified specialists (Curtis 1971, 59). In 1973, only 22 percent of Meharry's 2,257 alumni and 26 percent of Howard's 2,756 alumni were board certified, while 43 percent of all American physicians held those credentials (Martin 1975). Minority physicians had received full specialty training at only about one-half the rate of other American physicians.

National, state, and local health care and health manpower policy and incentives should reflect the need to correct this historical disadvantage in medical education and training suffered by Blacks and other underrepresented ethnic minority groups. Specifically, minority group communities do indeed suffer from a shortage of primary care physicians, but they suffer from a still greater shortage of specialists in all fields as well. Public health policy, and health planning guidelines, should address both of these needs.

This demand and need will continue as long as the Black population continues to be concentrated in large urban centers, clustered in racially segregated neighborhoods, and there is a national commitment to provide all our citizens with a single high standard of medical, hospital, and health-related services.

As we have seen, a larger number of minority students than ever before have been graduating from the nation's schools, and entering postgraduate training programs. By 1980, we were in a position to answer two questions: (1) Are minority students now entering specialty training programs with the same frequency as their nonminority classmates? and (2) Are they choosing specialties in a similar or different pattern from that of their nonminority peers?

FINDINGS AND DISCUSSION

YEAR-TO-YEAR SPECIALTY CHOICE FREQUENCIES OF BLACK AND NONMINORITY INTERNS

Table 18 provides data on year-to-year specialty choices for Black and for nonminority interns in the major fields. Since Blacks made up the overwhelming proportions of all minority interns, their numbers are sufficiently large to make comment on meaningful year-to-year trends. Nonminorities are of course almost all White, and, therefore, this table provides the most direct comment on differences in specialty choice patterns between Black and White interns.

While flexible or rotating internships were chosen with roughly equal frequency by Blacks and Whites over the five-year period, the year-to-year trends add important information. The declining popularity of flexible programs was much more marked for nonminorities, dropping from 28 percent to about 7 percent, than for Blacks, who went from about 15 percent down to 10 percent.

General surgery programs were equally popular with both groups in the combined five-year period, and there was no clear pattern in the year-to-year trend.

Obstetrics and gynecology, on the other hand, was chosen by almost three times as many Black interns as by nonminorities, and year-to-year data suggest that this trend was sustained over the study period.

Internal medicine was chosen equally by Blacks and by nonminorities and was clearly the most frequently chosen of any specialty field. Family practice programs, however, were more popular with nonminority interns

at times by a two to one margin, but the year to-year trend suggests that in the last year, Blacks were choosing this field with increasing frequency.

Pediatrics seems to have been slightly more popular with Black interns, but the year-to-year trend suggests that this field may be chosen equally by both groups.

Nonminorities seemed to choose all other fields with greater frequency. This category included all the other medical, surgical, and support specialty services.

COMPARING MALE AND FEMALE SPECIALTY
 CHOICES IN THE MINORITY AND
 NONMINORITY SAMPLES

Table 19 presents data on the entire minority sample, including all other ethnic underrepresented subgroups along with Blacks, compared with the

TABLE 18. Specialty Choices of Blacks and Nonminority Interns, 1973–77

Specialty	Total		1973		1974		1975		1976		1977	
	<i>N</i>	%										
Flexible												
Black	215	12.3	25	15.2	52	18.8	49	12.2	45	9.7	44	10.1
Nonminority	280	13.2	47	28.0	75	24.5	55	11.3	61	10.4	42	7.4
Surgery												
Black	247	14.2	22	13.3	35	12.7	65	16.2	68	14.6	57	13.1
Nonminority	303	14.3	21	12.7	52	17.0	76	15.6	78	13.3	76	13.4
OB-GYN												
Black	207	11.9	16	9.7	29	10.5	47	11.7	54	11.6	61	14.0
Nonminority	94	4.4	4	2.4	9	2.9	25	5.1	25	4.3	31	5.5
Internal Medicine												
Black	600	34.4	62	37.6	90	32.6	144	35.8	160	34.3	144	33.0
Nonminority	718	34.0	47	28.3	96	31.4	179	36.8	201	34.2	195	34.3
Family Practice												
Black	130	7.4	9	5.5	8	2.9	28	7.0	41	8.8	44	10.1
Nonminority	257	12.2	13	7.8	23	7.5	59	12.1	91	15.5	71	12.5
Pediatrics												
Black	217	12.4	20	12.1	40	14.5	46	11.4	61	13.1	50	11.5
Nonminority	217	10.3	21	12.7	25	8.2	43	8.8	59	10.0	69	12.1
Other fields												
Black	129	7.4	11	6.7	22	8.0	23	5.7	37	7.9	36	8.3
Nonminority	245	11.6	13	7.8	26	8.5	49	10.1	73	12.4	84	14.8
Total												
Black	1,745	100.0	165	100.1	276	100.0	402	100.0	466	100.0	436	100.1
Nonminority	2,114	100.0	166	99.7	306	100.0	486	99.8	588	100.1	568	100.0

entire nonminority sample in the combined 1973–77 time period. The most immediately apparent observation is that there were more minority women in their total sample (23 percent) compared to nonminority women (only 16 percent), a difference that is statistically significant ($p < .01$). We considered it important, therefore, to determine whether the men and women within these two samples were expressing different frequency patterns of specialty choice. We also had to observe the possibility that differences between the minority and nonminority samples as a whole might have come about just on the basis of a greater proportion of women within the minority sample, since it is a common observation

TABLE 19. Minority and Nonminority Internships, by Sex and Specialty

Specialty	Minorities			Nonminorities		
	% Choosing	<i>N</i>	% M/F	% Choosing	<i>N</i>	% M/F
Flexible	12.2			13.8		
Male		203	78.7		235	86.4
Female		55	21.3		37	13.6
Surgery	13.0			14.0		
Male		248	90.2		263	88.3
Female		27	9.8		35	11.7
Surgical specialty	2.2			3.0		
Male		39	84.8		54	84.4
Female		7	15.2		10	15.6
OB-GYN	10.4			4.2		
Male		163	74.4		69	77.5
Female		56	25.6		20	22.5
Internal Medicine	32.2			33.5		
Male		534	78.5		610	85.8
Female		146	21.5		101	14.2
Family Practice	9.3			11.3		
Male		152	77.2		215	85.7
Female		45	22.8		36	14.3
Pediatrics	12.2			9.8		
Male		143	55.6		153	73.9
Female		114	44.4		54	26.1
Psychiatry	3.2			4.0		
Male		52	76.5		66	77.6
Female		16	23.5		19	22.4
Others	5.1			6.7		
Male		87	79.8		118	31.9
Female		22	20.2		26	18.1
Total		2,109	100.0		2,121	100.0
Male		1,621	76.9		1,783	84.1
Female		488	23.1		338	15.9

that men and women physicians generally show different specialty career patterns.

FLEXIBLE PROGRAMS

No significant differences were observed between the percentages of minorities and nonminorities who chose flexible programs (12.2 percent versus 13.8 percent), nor in the relative proportions of men or women within either group who chose flexible programs (21.3 percent of minority women chose flexible programs compared to 13.6 of nonminority women, but these proportions were within the expected range of numbers based on the total number of women in each respective group).

SURGERY

Minority and nonminority interns chose GME-I surgery programs with almost equal frequency (13.0 percent versus 14.0 percent). In the nonminority group, men preferred surgery significantly more frequently than women ($p < .05$), but the male preference for surgery programs was significantly greater among men in the minority group. Minority women chose surgery programs significantly less often ($p < .01$) compared to all others combined, and in separate comparisons to minority men, or nonminority men or women. While this is an interesting initial observation, we can only speculate that it may have been a result either of more vigorous recruiting of nonminority than of minority women in a response to affirmative action challenges, or that fewer minority women are interested in surgery.

OBSTETRICS AND GYNECOLOGY

Minorities chose programs in obstetrics and gynecology with significantly greater frequency than did nonminority classmates ($p < .01$). This preponderance of minority interns reflects the choice of women as much as men, since the sexes are represented in that specialty in the same proportions as in the overall minority sample. Among nonminority interns, women were more highly represented in this field than in the sample as a whole, but the finding is of only borderline statistical significance. A significantly greater proportion of minority women go into obstetrics and gynecology ($p < .01$).

MEDICINE

Minorities and nonminorities, as well as men and women within these groups, chose medicine programs in approximately proportionate numbers.

FAMILY PRACTICE

Significantly more nonminorities chose family practice ($p < .01$), but within both groups these programs were equally popular with men and women.

PEDIATRICS

Pediatrics was significantly preferred by minority interns over nonminorities ($p < .02$); and in both groups, there was a great overrepresentation of women ($p < .01$). Proportionately many more minority women ($p < .01$) entered this field. It is the strong popularity of pediatrics among minority women that accounts for its greater popularity with minority interns.

PRIMARY CARE GME-I PROGRAMS

Primary care programs are defined by NIRMP as consisting of internal medicine, family practice, and pediatrics; and the generalist specialties include obstetrics and gynecology and general practice (Graetinger 1978).

Defined in this way, minorities entered the generalist programs significantly more ($p < .01$) than nonminority interns; but there was no difference in their overall rates of entry into primary care programs as defined. In other words, the heavy participation of minorities in obstetrics and gynecology programs and the reclassification of that specialty from a specialty to a generalist category chiefly differentiate the specialty choice patterns of minority interns as more generalist in nature.

However, while there is no significant difference in the representation of men and women within the nonminority sample in terms of their participation in primary care or generalist programs, a significantly higher

TABLE 20. Specialty Choice Differences among Minorities, by Economic Status

	All Minorities (<i>N</i> = 2,016)		NMF Nonapplicant (<i>N</i> = 333)		NMF Reject (<i>N</i> = 274)		NMF Awardee (<i>N</i> = 1,404)	
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
Flexible	260	12.9	40	12.0	40	14.6	180	12.8
Surgery	277	13.7	45	13.5	42	15.3	190	13.5
Surgical Specialty	47	2.3	10	3.0	5	1.8	32	2.3
Family Practice	198	9.8	34	10.2	27	9.8	137	9.7
Medicine	685	34.0	108	32.4	95	34.7	482	34.2
Psychiatry	68	3.4	12	3.6	7	2.6	49	3.5
OB-GYN	219	10.9	32	9.6	27	9.9	160	11.3
Pediatrics	262	13.0	52	15.6	31	11.3	174	12.7

proportion of minority women than their overall representation in the sample ($p < .01$) chose to go into the combined fields of internal medicine, family practice, and pediatrics, with or without combining these fields with obstetrics and gynecology.

We conclude that minority women more often chose programs in primary care or the generalist specialties ($p < .01$), and went into surgery programs less often compared to minority men, nonminority men, and nonminority women.

SPECIALTY CHOICE DIFFERENCES WITHIN THE MINORITY SAMPLE

ECONOMIC DISADVANTAGE WITHIN THE MINORITY SAMPLE

The data in table 20 show that minority group graduates did not make specialty choices in any demonstrable relationship to their financial circumstances. The assumptions we made about NMF in chapter 4 apply again here.

Clearly all the economic subgroups discussed in chapter 4 made similar specialty choices for their GME-1 year, a convincing demonstration that differences in financial resources, at least in the ranges described, exerted no measurable effect on the specialty training preferences of minority medical school graduates, even though the most economically disadvantaged group had average family incomes that were only slightly more than half that of the other groups.

ETHNIC MINORITY SUBGROUPS WITHIN THE MINORITY SAMPLE

Table 21 summarizes the GME-1 specialty choices for the four under-represented minority subgroups: 1,745 Blacks, 233 Mexican Americans, eighty-five Puerto Ricans from the U.S. mainland, and twenty-nine Native Americans. Of course the latter two subgroups are so few in number that any trends are only suggestive.

Comparing Blacks to all the other minority groups combined revealed that significantly more of the other minority groups than Blacks went into family practice ($p < .01$). Except for Puerto Ricans, proportionately more Blacks went into internal medicine ($p < .01$). Their choices of surgery were not significantly different. However, the preference of minorities for obstetrics and gynecology reflects the choice of Blacks ($p < .01$) more than of the other minority subgroups. Also there was a suggestion of greater

preference of Mexican Americans, compared to Blacks, for the support specialties (defined as pathology, anesthesiology, radiology, physical medicine, and diagnostic and therapeutic radiology [Graetinger 1978]), but this difference is not statistically significant.

DIFFERENCES WITHIN THE BLACK SUBGROUP

Table 22 shows differences within the Black subgroup. Our data revealed that Blacks who graduated from medical schools from 1973 to 1977 were not a homogeneous group. Take the most obvious first question: do graduates of Meharry choose different specialties than graduates of Howard? The answer is yes, there are significant differences. The pattern of specialty choices differs for Howard and for Meharry ($p < .01$; all Howard or Meharry graduates who were not Black excluded). A greater number of Meharry graduates went into flexible GME-I programs; more Meharry interns went into surgery programs; fewer Meharry graduates went into internal medicine, the support specialties, and the medical or surgical specialties.

The overall pattern of specialty choice is different for Blacks who graduated from all other medical schools combined, compared either to Howard or to Meharry graduates. Table 22 shows that Howard graduates more closely resembled the graduates of predominantly White medical schools. Compared to Howard graduates, Blacks who graduated from predominantly White schools less often chose flexible programs, and more often chose medicine or family practice. Blacks in all categories show a

TABLE 21. Specialty Choice, by Minority Subgroup

	Black (<i>N</i> = 1,745)		Mexican American (<i>N</i> = 223)		Puerto Rican Mainland (<i>N</i> = 85)		Native American (<i>N</i> = 29)		Other Non-Black Minorities Combined (<i>N</i> = 337)	
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
Flexible	215	12.3	33	14.7	8	9.3	4	13.8	45	13.3
Surgery	247	14.0	25	11.2	8	9.3	3	10.3	36	10.6
Surgical Specialty	26	1.5	3	1.2	0	0.0	2	6.9	5	1.5
OB-GYN	207	11.7	19	8.5	3	3.5	2	6.9	24	7.1
Pediatrics	217	12.4	31	13.8	17	19.8	3	10.3	51	15.1
Family Practice	131	7.4	47	21.0	10	11.6	8	27.6	65	19.2
Internal Medicine	600	34.1	44	19.7	35	40.7	6	20.6	85	25.2
Medical Specialty	61	3.5	7	3.0	2	2.3	1	3.4	10	2.9
Support Specialty	42	2.6	14	6.1	0	0.0	0	0.0	14	4.1

similar high frequency of choice of obstetrics and gynecology. More of Howard's graduates chose the support specialties, or medical or surgical subspecialties in comparison to other Black interns.

DISCUSSION

FLEXIBLE OR ROTATING INTERNSHIPS

Earlier we reported that these programs experienced a decline in popularity in the 1973-77 five-year period both for minority medical schools graduates (going from 15 to 10 percent) and even more for nonminority graduates (from 28 to 7 percent). This mirrors the finding reported by Graettinger (1978) on nationwide NIRMP trends that only about one-third as many U.S. graduates in 1974 went into flexible programs compared to U.S. graduates who entered flexible or rotating programs in 1977. Some six thousand of approximately seventeen thousand positions offered in all programs in 1974 were rotating or flexible, of which three thousand were filled; in 1977, of seventeen thousand positions offered, two thousand were flexible, and just a few over one thousand were filled (figures are rounded to the nearest thousand). Reasons for the declining popularity of these programs are complex, and have been reviewed by Graettinger (1978), but mainly reflect the increasing interest of U.S. graduates in pursuing some form of specialty training. At one time a broadly diversified or rotating postgraduate training, for one year after medical school graduation, was all that usually was required to apply for a license to practice medicine. This

TABLE 22. Specialty Choice within Black Subgroup, Historically Black Schools versus Others

	All Blacks (N = 1,745)		Schools other than Howard or Meharry (N = 1,473)		Howard and Meharry Combined (N = 272)		Meharry Alone (N = 149)		Howard Alone (N = 123)	
	N	%	N	%	N	%	N	%	N	%
Flexible	215	12.3	156	10.6	59	21.7	40	26.8	19	15.4
Surgery	247	14.0	207	14.0	40	14.7	30	20.1	10	8.1
Family practice	130	7.4	122	8.3	8	2.9	4	2.7	4	3.3
Internal medicine	600	34.1	543	36.8	57	21.0	23	15.4	34	27.6
OB-GYN	207	11.7	165	11.2	42	15.4	23	15.4	19	15.4
Pediatrics	217	12.4	189	12.8	28	10.3	15	10.1	13	10.6
All others	129	7.4	91	6.2	38	14.0	14	9.4	24	19.5

Note: The overall pattern of specialty choices of minority students at all other medical schools in comparison with minority students at either Howard or Meharry is statistically significant at $p < .01$. Howard and Meharry are also significantly different from each other ($p < .01$).

no longer is considered adequate. Further, several specialty boards abolished the rotating or general internship as a required, separate, initial year of training for certification in their field. The change in name as well as purpose led to the decline in popularity of these programs.

In this light, it is important to note that Meharry graduates, unlike other Blacks and other minority interns, were still selecting flexible or rotating internships more than twice as often as other minority interns. This may mean that more Meharry graduates were planning to enter general practice careers after a year of postgraduate training. Private communications with the dean's staff both at Meharry and at Howard indicated that within the two years after 1977, increasing percentages of their graduates were selecting primary care or other specialty programs, and fewer were going into flexible programs.

ARE MINORITY STUDENTS ENTERING
SPECIALTY TRAINING AS FREQUENTLY AS
THEIR NONMINORITY CLASSMATES?
IF SO, SHOULD THEY?

Whether we consider the entire minority sample, as shown from data reported in table 19, or the Black subgroup only as shown in table 18, it seems clear that minority graduates in the five-year 1973–77 time period were beginning specialty training at a rate equal to that of their nonminority peers. This undoubtedly was the first five-year period in the history of American medical education, or of American postgraduate medical training, for which this statement could be made. Undoubtedly, this was a notable achievement in the first decade of affirmative action minority admissions programs, which were undertaken with the aim of broadening and diversifying the base of American medical manpower by removal of ethnic barriers to medical educational opportunity.

Why is it a clear social and medical care gain that Blacks and other ethnic minorities should be specialized in equal proportions to their nonminority physician colleagues? Because even though only about 25 percent of living Howard and Meharry alumni were board certified (compared to 43 percent of living alumni of other medical schools), this did not represent their free choice, but rather was the result of a century of racially discriminatory denial of training opportunity.

U.S. medical school graduates in the 1960s and 1970s became much more completely specialized than ever before. Levit et al. (1974) tracked a sample of graduates from the classes of 1960 and 1964 and found in 1974 that postgraduate education had become a standard component of an

American physician's education. In their sample of over thirteen hundred physicians, 90 percent had entered some form of residency training, 73 percent had completed their training, and about 62 percent had become board certified. It took at least twelve years after medical school graduation to obtain a reliable estimate of how many of them probably would eventually achieve board certification. Specialization will continue at this rate both for nonminority and minority physicians so long as it remains the only route to professional status, monetary reward, academic advancement, hospital admitting privileges, and inner feelings of personal achievement and self-esteem.

Most Black physicians, like their White colleagues, indicate that they limit their practice, or otherwise identify themselves as specialists, on the American Medical Association questionnaires periodically submitted to them. They do so whether they have passed their specialty board examinations and achieved formal certification status or not. While some physicians have completed all, and many have completed part, of their specialty training, equality of educational and training opportunity for minority physicians has only recently become a reality. Table 23 provides data on the self-designation of specialty practice as reported by alumni from all U.S. medical schools and from Howard and Meharry alumni. About one and a half times as many Black physicians were general practitioners in 1973 as all other physicians, certainly a significantly greater proportion of generalist or primary care physicians in that category alone. Surprisingly, however, it will be noted that the percentages of Blacks who identified themselves as specializing in the medical and surgical specialties rather closely match the percentages of nonminority practitioners so classifying themselves. A physician licensed to practice medicine within a given state

TABLE 23. Self-Designated Specialty, Alumni of Historically Black Schools versus Others

	Alumni from all U.S. Schools (<i>N</i> = 286,741)		Howard Alumni (<i>N</i> = 2,756)		Meharry Alumni (<i>N</i> = 2,257)	
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
General practice	45,471	15.6	609	22.1	620	27.4
Medical specialty	69,009	24.0	591	21.4	399	17.7
Surgical specialty	74,954	26.1	693	25.0	660	29.2
Other specialty	66,336	22.9	561	20.2	356	15.9
All others	30,971	10.9	302	10.8	222	9.7

Source: Data obtained from Martin 1975, 38,52, 53, 109.

is allowed freedom to practice as a generalist or as a specialist, with a great deal of local variation in standards of practice required. One can only conclude, therefore, that the aspiration level of all American physicians is highly similar, and that aspirations to high standards also are generally high, but that opportunity only now is at the point of converging these equal ambitions with equal skills. Many if not most Black patients, confined to segregated ghetto neighborhoods in large cities or in rural areas, were becoming the beneficiaries of more equal specialist health care.

At the same time, as the nation relaxes its racial restrictions and desegregates its living arrangements in all areas, Black and other minority physicians of the future will be prepared to join their nonminority peers in making equal leadership contributions to all areas of American medicine, not only as general practitioners but also as specialist consultants, teachers, researchers, administrators, and health planners and policymakers.

While we await the further desegregation of American society, including medical affairs, highly trained minority specialists will be required to operate first-class medical services in the hospitals, clinics, group practices, and private offices located in segregated neighborhoods. An argument therefore could be made for encouraging minority medical school graduates to enter specialty training programs, even in those specialties that currently are overcrowded with nonminority specialists. Without doubt this would increase the chances, within a city, county, or state, of having a specialist who would voluntarily choose, rather than be forced or required, to serve in an ethnically unpopular geographical area. Furthermore, it is degrading and demoralizing for Black Americans to live in a society in which all the experts and specialists are White.

ARE MINORITY INTERNS MORE LIKELY TO CHOOSE A PRIMARY CARE CAREER?

Minority women as a group stood out in the frequency with which they chose to go into the combined fields of family practice, medicine, and pediatrics, especially because of their high preference for pediatrics. In this they differed from minority males, as well as from nonminorities of either sex. Since women made up a relatively larger proportion of the minority sample, an increasing supply of minority interns will automatically increase the proportion of primary care interns. The proportionately greater number of minority women among minority medical students has been described by Johnson, Smith, and Tarnoff (1975) on students entering all U.S. medical schools in 1972–73: among Caucasians, 16 percent were fe-

male, among Blacks, 29 percent, Native Americans, 24 percent, Mexican Americans, 14 percent, and Puerto Ricans, 20 percent.

ARE MINORITY INTERNS MORE LIKELY TO
ENTER ANY PARTICULAR SPECIALTY?

The answer is yes. Obstetrics and gynecology was preferred two to three times more often by Black medical school graduates, compared to other medical school graduates, and was chosen by Black men and women proportionately. One reason may be that the field is no longer generally popular with medical school graduates, does not attract the graduates with the highest academic records, and therefore is easier to enter with a good post-graduate training placement. This would not explain the fact that Blacks expressed the same decided preference for obstetrics and gynecology (Johnson, Smith, and Tarnoff 1975) at the time they applied to medical school. They also held on to their choice of this field with more than average tenacity compared to students who chose other fields, as was shown in a study of specialist choice stability, measuring specialty choice at the beginning and again at the end of the medical school years. That study (Cuca 1977) of all 1976 graduates of U.S. medical schools also found that Blacks more often selected public health, but in our sample so few students selected that field that we could not confirm that finding.

My speculation on the reasons for the popularity of obstetrics and gynecology are as follows: Blacks are attracted to obstetrics and gynecology because in earlier decades this specialty above all others was plagued by blatant racial prejudice and practice. Black women in past decades were not admitted to most women's hospitals in this country, even if they were attended by a White physician. Black medical students or practicing physicians usually were not allowed to examine or treat women patients except in racially segregated hospitals. This created an early, strong, and separate market demand for Black physicians to provide this special medical care for their Black women patients.

Blacks have been sensitive to the knowledge that their rates of maternal and infant mortality are higher than for the nonminority group, reflecting inequities in the general health care delivery and health maintenance systems.

Blacks have had higher than average rates of fertility, a larger family size, more out-of-wedlock, teenage, or other problem pregnancies. This has served to expose many young minority physicians to traumatic memories from personal family, and neighborhood experience, alerting them to

special needs in this area. Problems dealing with sexually transmitted diseases, disorders of sexual function, and problems of infertility were also common, further explaining a stronger than usual demand for medical service in this area.

Obstetrics and gynecology had, for all the above reasons, been an especially necessary and popular field for many decades, and this factor of itself served as a magnet to attract more than an average number of young physicians into the field. Several of the great teachers on the faculty of Howard and at Meharry were specialists in obstetrics and gynecology (personal communications with deans). For example, among Howard's 2,756 alumni, an unusually large number of 266 (9.1 percent) identified themselves as obstetricians and gynecologists in 1973, second only to the 333 who identified themselves as internists; while for all 286,741 U.S. medical school alumni only 16,330 (or 5.6 percent) were in obstetrics and gynecology (Martin 1975).

Obstetrics and gynecology probably will attract and should continue to attract a greater than average proportion of minority physicians as long as the factors mentioned above continue to operate. It is a matter of social importance that physicians meeting these intimate and special needs receive the highest level of specialist training and skill. This is a good example of the desirability and fairness of setting different and higher objectives for allocations of training, and of other health services, in order equitably to meet a currently different level of health care need in a defined minority group community.

At the same time, it is clear that as the economic, social, and cultural life experiences of the various minority groups more closely approximate those of other Americans, their health needs and health-planning profiles will become increasingly similar to those of the nation at large. Recent gains made in postgraduate training opportunities for minority groups mean that we are putting an end to producing first-class and second-class physicians for first-class and second-class racial groups. Future American physicians will clearly be able to provide a single high level of sensitive health care and health maintenance for all patients who seek their services, and an increasingly well educated American public will eventually outgrow its preference for a racially segregated medical market.

SUMMARY

A sample of 2,109 minority graduates from U.S. medical schools were compared to a sample of 2,121 nonminority graduates for the five-year period 1973-77, comparing the internship programs for which they were

matched through the National Intern and Resident Matching Program. While currently living Black physicians are board certified at only approximately half the rate of White physicians, recent minority medical school graduates are entering postgraduate specialty training programs in the same frequency as their nonminority peers. Some differences are noted: more minority interns select obstetrics and gynecology, fewer select family medicine programs. Minority women more often choose programs in pediatrics and less often choose programs in surgery, compared either to minority men or to nonminorities of either sex. Other findings suggest that important differences in specialty choice may be found within the minority group sample. Degree of economic disadvantage in family background of minority interns does not account for differences in specialty choice.

Health planning at national, state, and local regional levels should take into account the fact that minority communities, served predominantly by minority physicians, have been deprived of a fair share of specialists as well as general and primary health care practitioners. Equitable resource allocation should allow for increased numbers of minority physicians to be trained in all specialty areas, as these physicians will be the most likely resource for voluntarily directing and staffing the health and hospital facilities and programs to serve minority group communities.