

viii. The Future of Affirmative Action

IN MEDICINE

THE PAST THIRTY YEARS have witnessed a remarkable improvement in medical educational opportunity for Black Americans. In this final chapter I outline the nature of these changes, then review the substantial legal and political assault that has been launched against this progress, and summarize the rationale for continuing the effort. Special reference will be made to the implications for Black Americans because the history of our nation, in its early economic beginning, was founded on slave labor. Affirmative action represents a recent attempt to overcome the enduring system of color caste that continues to blight the lives of all Americans. A concluding section deals with the feasibility of success in the recently mounted national affirmative action effort to equalize the health status of African Americans with other ethnic groups.

Table 44 shows that from 1968 to 1997 total medical school enrollment nearly doubled, from just under thirty-six thousand in 1968 to just under sixty-seven thousand in 1997 (AAMC 1978, 299; 1998). Whereas women represented only 8.8 percent of all medical students in 1968, their share increased to 24.3 percent by 1978 and to 42.6 percent in 1997. This spectacular affirmative action achievement for women did not produce a significant political backlash. Indeed the AAMC never officially launched an affirmative action admissions program for women as they did for minority groups in 1970. The program for women was silent, unannounced, but hugely successful. Another little-noted change, similarly unannounced, was among Asian Americans, who went from a little over 2.0 percent of all medical students in 1968 to 18.4 percent by 1997. Among underrepresented minority groups the progress of Black Americans is shown by their growth from 2.2 percent of all medical students in 1968, to 5.7 percent in 1978 and to 7.9 percent in 1997.

This improvement has sparked one of the most impassioned debates in our generation. Black Americans made similar gains in the fields of

law, business administration, and engineering, all resulting from race-sensitive admissions programs. It should also be noted that currently more White males are enrolled in medical schools than during pre-affirmative action years, and that all groups benefited from the almost doubling of medical school places from 1968 until now. A rising tide lifted all boats.

In 1980 Blacks represented 11.5 percent of the total United States population of 226 million, but only 3.1 percent of the 433,255 physicians in our nation. A decade later in 1990, Blacks were 11.7 percent of the 249 million total population and now were 3.6 percent of the 586,715 physicians in the United States (AAMC 1998). Blacks are still far from being represented equally among our nation's physicians. Projections of the nation's physician workforce suggest that it may be another fifty years before the proportion of Black physicians achieves parity with the proportion in the general population (Watson 1999).

In 1968 Howard and Meharry enrolled approximately 85 percent of all Black American medical students. By 1997, two new predominantly Black medical schools had been established: Morehouse School of Medicine in Atlanta, which was founded in 1978, and the Charles R. Drew University of Medicine and Science, which admitted its first class in 1981. The total number of Black Americans enrolled in these four schools in 1998 was 712, or 13.4 percent of all Black American medical students, distributed as follows: Howard 125, Meharry 301, Morehouse 123, and Drew 23 (AAMC 1998). This represents a dramatic desegregation of medical education over the past thirty years.

TABLE 44. Total Enrollment in U.S. Medical Schools, 1968, 1978, 1997

	1968		1978		1997	
	Total	%	Total	%	Total	%
Number of Schools	99		124		127	
Total Students	35,833		62,242		66,900	
Men	32,697		47,149		38,395	57.4
Women	3,136	8.8	15,113	24.3	28,505	42.6
Underrepresented minorities	854	2.4	4,901	7.9	8,178	12.2
Black	783	2.2	3,540	5.7	5,303	7.9
Mexican American	59	0.2	882	1.4	1,838	2.8
Native American	9	0.03	202	0.3	561	0.8
Puerto Rican (Mainland)	3	.008	277	0.5	476	0.7
All others	932	2.6	3,595	5.8	14,828*	22.2

Source: AAMC enrollment data for 1968, 1978, 1997.

*Asian or Pacific Islander = 12,303, or 83% of total.

AFFIRMATIVE ACTION IN MEDICAL EDUCATION

A number of specific anti-affirmative action lawsuits and new laws have created heated controversy (Bergeison and Cantor 1999).

1. In 1995 the University of California regents decided to prohibit the use of race, religion, sex, color, ethnicity, or national origin as a criterion for admission effective January 1, 1997.
2. Proposition 209 in California and Initiative 200 in the State of Washington were passed by voters respectively in 1996 and 1998 prohibiting race-sensitive admissions, public employment, or public contracting.
3. *Hopwood v. Texas* in 1997 forbade the University of Texas from using race as an admission criterion, a decision by the Fifth Circuit Court of Appeals, which covers also Mississippi and Louisiana.
4. In December 1998 the First Circuit Court of Appeals, in *Wessman v. Gittens*, ruled that an admissions set-aside for minority applicants at Boston Latin School was unconstitutional (this action brought these suits to the secondary school level).
5. Two pending class action cases against the University of Michigan, *Gratz et al. v. Bollinger* and *Grutter v. Bollinger*, challenged the use of race in admissions decisions in the undergraduate and law schools.

Some of these, and other expected legal challenges, are aimed not only at state-operated colleges and universities, but also at private institutions that receive federal funds of any kind. Programs for minority high school students only that help them to become better prepared for college would also be curtailed. Indeed some of these opponents would be against any kind of special program to enhance the acceptance chances of minority students, viewing them as reverse discrimination against Whites. Blacks would thereby be locked permanently into an underclass status.

In the May 7, 2001, issue of the *American Prospect*, Alexander Wohl calls these reverses to affirmative action "Diversity on Trial." He called attention to litigation against the University of Michigan's admission policy. On December 13, 2000, a federal district judge appointed by Ronald Reagan upheld the constitutionality of race-conscious undergraduate admissions to the Michigan undergraduate school. Three months later in the same district court another Reagan appointee, Judge Bernard Friedman, held that the race-conscious admission program at the university's law school was unconstitutional. Some observers particularly stressed the seriousness of Judge Friedman's opinion that it has not been shown that there is a compelling state interest in assuring ethnic diversity in a class, that "race-neutral" alternatives to affirmative action should have been tried,

including “decreasing the emphasis for all applicants on undergraduate GPA and LSAT scores, using a lottery system for all qualified applicants, or a system whereby a certain percentage of the top graduates from various colleges or universities are admitted.” This abandonment of objective standards of academic measurement is precisely what has occurred in California, Florida, and Texas in the wake of attacks on race-sensitive affirmative action. Since the quality of schools varies so widely, the top schools in the state systems could find themselves admitting less qualified students and minority students might choose to attend less competitive segregated schools to increase their chances of admission, in short, lowering academic standards in the premier state university units (Selengo 2001; Rosen 2001).

This adverse Michigan decision, combined with the adverse decision in 1996 ruling against the University of Texas law school admissions for minority applicants and the favorable decision on the University of Washington’s law school admissions in 2000, made it appear increasingly likely that this issue will be brought to the Supreme Court soon. Matters became still more clouded on May 14, 2002, when the U.S. Court of Appeals for the Sixth Circuit said it was not yet ready to rule on the lawsuit involving undergraduate admissions but decided 5 to 4 to overturn a lower court’s ruling that the University of Michigan’s law school had illegally discriminated against White applicants. The court said the university had considered race appropriately in trying to enroll a “critical mass” of minority students to contribute to educational diversity (Schmidt 2002).

The basic legal ambiguity is derived from the Supreme Court’s decision in 1978 in the case of *Regents of the University of California v. Bakke*. Justices Brennan, White, Marshall, and Blackmun would have supported the use of a quota to give equal opportunity under the Fourteenth Amendment, while another four justices opposed race-conscious admissions under federal law—Justices Stevens, Stewart, Rehnquist, and Chief Justice Warren Burger. Justice Lewis Powell’s majority opinion was that while quotas setting aside admission places were not permissible, race can be considered as one factor in making admissions decisions in order to promote diversity and an improved educational experience for all students in a class. Because “diversity” and “Academic freedom,” a First Amendment concern, were the basis for Powell’s decision and none of the other justices took that precise stand, there is confusion concerning how the present Supreme Court would decide.

Wohl (2001) and others are fairly certain that Chief Justice Rehnquist will be joined by Justices Scalia and Thomas, who are believed to be strongly opposed to affirmative action, and possibly Kennedy, who has

“shown great skepticism about affirmative action in previous cases.” On the other side, Justices Ginsburg, Breyer, and Souter would likely be joined by Stevens, who has not concluded that race can “ever be used as a factor in an admissions decision.” For these reasons it is speculated that Justice Sandra O’Connor might make the decision on the constitutionality of minority admissions. Her previous decisions opposing affirmative action set-asides in business contracts and employment were, in her own words, not to be taken as opposition to “achieving diversity in public graduate schools.” Justice O’Connor is believed to favor the stand of former justice Powell in preferring to favor a decision based on a limited scope such as “diversity” rather than the broader scope of the Fourteenth Amendment’s equal protection clause.

Reminding us that the Supreme Court’s *Brown v. Board of Education* in 1954 found segregated schools unconstitutional, with all justices concurring that they violated the fourteenth Amendment’s equal protection clause, and that the following year Brown II recommended that desegregation proceed with “all deliberate speed,” James Patterson in his recent book concludes that within ten years most southern schools had become nominally desegregated. Its effects were nullified by southern Whites flight to the suburbs, setting up private schools and setting up ability-tracking systems that kept the races apart even within the same school. Segregation still prevailed in the North through de facto residential segregation. For all these reasons the academic achievement gap between Black and White child persists, and little is being done nationally to fight continued racially segregated neighborhoods (J. T. Patterson 2000). We should bear this in mind as we speculate on the possible consequences of how the present Supreme Court may rule on cases soon to come before it on affirmative action in higher education. Whether the court decides positively or negatively will not necessarily matter very much. The Warren Court realized in the 1950s that “courts by themselves could not greatly change American society.”

PROBLEMS IN PREPARING MINORITY STUDENTS FOR ADMISSION

Since it began operations in 1972 the Robert Wood Johnson Foundation has supported programs to increase the enrollment of minority medical students as well as the development of minority faculty. Specifically, the Minority Medical Education Program (MMEP) provides an intensive six-week residential summer program for minority premedical students to enhance the likelihood of their being accepted. At eight different medical

schools these students receive training to improve their science course preparation, hone test-taking and communication skills, and learn the fine points of the application process. As of 1991 nearly half of all U.S. medical schools sponsored some variety of preprofessional programs. Minority students applying for acceptance into the MMEP are required to complete a process that closely parallels the one they will complete later, through the American Medical College Application Service (AMCAS), which provides uniform application forms and procedures and is used by almost all medical schools.

Applicants to MMEP must submit their undergraduate college admission test scores, transcripts of grades, a personal statement of their interest in a medical career, and letters of recommendation. A minimum grade point average of 3.0 (on a 4.0 scale) is expected, including at least a 2.75 in the science courses and a score of at least 950 on the Scholastic Aptitude Test (SAT). Since applicants are expected to show these threshold levels of academic potential, the program does not actually increase the pipeline of acceptable minority applicants. A short-term six-week program could not develop an unprepared student. In collaboration with the Association of American Medical Colleges (AAMC), the Prematriculation questionnaire, which provides information on the applicant's family background, is administered along with the Medical College Admission Test (MCAT). Minority students participating in the foundation-sponsored preparatory program could be compared with minority premedical students who had not participated. Between the summers of 1989 and 1997 the Robert Wood Johnson MMEP had served 6,479 students, of whom 48.7 percent applied to medical schools, and 63 percent of those applicants were accepted. Acceptance rates for MMEP students were higher even after controlling for college grades and MCAT scores, and were as great for those who participated after their freshman or sophomore year as the upper division years. The six-week program also was demonstrably more effective with minority students who had relatively higher grades or MCAT scores. These favorable effects were maintained even in 1996 and 1997 after affirmative action litigation created a less welcoming environment (Bergeison and Cantor 1999; Cantor, Bergeison, and Baker 1998).

In 1991 the AAMC launched its program to admit three thousand underrepresented minorities (URM) by the year 2000. The target was 19 percent of all new medical school matriculants, equal to the proportion of underrepresented minorities in the U.S. population. Medical schools were encouraged to form linkages with minority high school students interested in a medical career and performing well academically, and also with col-

leges graduating large numbers of minority premed students. However, from 1994 with 2,014 first-year students, there was a drop in 1995 to 2,010 (Division of Community and Minority Programs 1996). The number continued to decline, to 1,770 in 1997, the lowest since 1991. After reaching a second high in 1994, URM new entrants declined from 12.4 percent to 10.9 percent of all entering medical students. This drop was specifically related to adverse affirmative action: Proposition 209 caused a 16 percent decline in California schools, a 29 percent decline in Texas, and a 13 percent decline in Mississippi and Louisiana, all states adversely affected by the *Hopwood* decision (AAMC 1998, 8–9).

Table 45 illustrates the downward trend of URM admissions during the past decade, 1990 through 1999. Unless new programs are mounted, we can anticipate further stagnation or decline in the decade to come. Not shown in this table is the fact that Black women are increasing their numbers, while Black men are progressively declining. As Theodore Cross and Robert Slater have shown (2000), up until the mid-1970s Black men earned nearly 75 percent of all professional degrees awarded to African Americans, but Black men won only 47 percent of all professional degrees in 1991 and 42 percent in 1997; Black men in 1977 won 60 percent of all doctorates but only 35 percent in 1998.

Specifically in medicine, in the decade of the 1990s, in 1994 of 1,384 Blacks admitted, only 550, or about 40 percent, were men, but in 1999 only 406 of the 1,199, or 34 percent, were men. While women of all groups are increasing their share of medical school admissions, their proportion still does not match that of men: in 1999 men were 54 percent of the 117 Native Americans admitted, 54 percent of 415 Mexican Americans, 50 percent of the 119 Mainland Puerto Ricans. Among Whites, of 11,030 admitted, 57 percent were men, in what continues to be a profession dominated by men.

TABLE 45. First-Year Underrepresented Minority Entrants to U.S. Medical Schools, 1990–99

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Black	1,104	1,147	1,262	1,350	1,384	1,365	1,266	1,202	1,269	1,119
Native American	72	102	121	138	134	152	154	137	155	117
Mexican American	281	328	427	399	476	504	470	418	435	415
Puerto Rican (Mainland)	105	125	118	105	136	116	146	116	111	119
Total	1,562	1,702	1,928	1,992	2,130	2,137	2,036	1,873	1,970	1,770

As Cross and Slater emphasize, the decline in the proportion of men in higher education in general took hold much earlier for Blacks than for Whites. One reason for this decline may be the possibility that recruiting Black women improves affirmative action targets both for gender and ethnicity. More basic causes may be the erosion of the Black family; in more than two-thirds of all Black households there is no father or other strong role model. The culture of the primary and secondary school system appears to favor young Black girls over boys since teachers, predominantly female, see more Black boys who are disciplinary problems. An antiachievement ethic may therefore have become more prevalent among male Blacks. Media portrayal of successful Black men concentrates on athletes and entertainers, occupations requiring little formal education, sending "large numbers of young Black males down a career-blind alley," to quote Cross and Slater. Educational enrichment programs aimed to attract larger proportions of Black males must therefore overcome special cultural hurdles.

Several medical schools have assumed the responsibility of increasing the pool of qualified minority applicants. The most noteworthy of them, perhaps, is the Gateway to Higher Education sponsored by the City University of New York Medical School (Slater and Iler 1991). This is a comprehensive four-year high school program with specially designed enrichments and supports. Established in 1986, the program is demonstrating that minority students in the ninth grade who are performing at least at grade level can show outstanding scholastic achievement by the time of high school graduation.

In 1990, the first 119 graduates of this program were freshmen at sixty different colleges and universities nationwide: two-thirds of the Gateway graduates scored 500 or better in the SAT mathematics section, 25 percent scored over 600, and all of them exceeded the national average on the SAT verbal section. The students responded positively to the increased demands, attendance at classes was nearly perfect, and only three dropped out of high school. The program, developed by Dr. Alfred Gellhorn while he was dean of the medical school, is a collaborative venture with the New York City Board of Education and is funded by a special state grant and private foundations at an average annual cost of twelve hundred dollars per student beyond the basic educational allotment.

Total enrollment in 1990 was six hundred students from five high schools. A junior high school component was added in 1990, so that more than one thousand students were participating in Gateway. The value of the program is illustrated by one finding: for Black students taking the SAT in that first graduating year, those in the Gateway had a mean total score of

978.3, while Black students nationally scored 737. However, if one wanted to be skeptical, one might suggest the Gateway students are more highly motivated and from more highly motivated families than average and therefore the program is just skimming off the better students who would have performed above average anyway. The medical school employs two full-time directors who collaborate with fifteen teachers at each participating school who are selected for their special interest in the program's goals. Three additional university-based professional level staff assist part time in scheduling special laboratory, computer tutorials, guidance, and development of a parent council interchange with teachers.

A ten-year follow-up by Iler and Slater (1998) showed continuing success of this program in sending high proportions of these students into college and professional careers in medicine, sciences, engineering, and technology. Their goal is to have 15 percent of their graduates entering medical school, and they have achieved 7 percent, approximately one-half of this goal, with their first graduates. In a national AAMC survey of minority students at high school level interested in pursuing a medical career, 47 percent of all of the New York state students were in the Gateway program (Iler and Slater 1998).

The Gateway program does not come close to the spectacular success of Xavier University, the only Black college affiliated with the Roman Catholic Church. The Xavier program is not under medical school auspices. Xavier was founded in 1915 in New Orleans by Katherine Drexel and the Sisters of the Blessed Sacrament at the request of the local archbishop, specifically because of the limited higher educational opportunity for Black youth (*Handbook of Historically Black Colleges and Universities* 1999, 109). With a current enrollment of 850 men and 1,973 women, Xavier for a number of years has been number one nationally in placing Black students in medical schools. In the year 2000 the top ten schools in producing Black first-year enrollees were Xavier (73); Morehouse (31); Howard University (26); Spelman (24); Johns Hopkins (19); Harvard (17); Hampton University (16); Oakwood College in Huntsville, Alabama, which is affiliated with the Seventh Day Adventist Church (16); University of Maryland-College Park (16); University of California-Los Angeles (15). Major reasons for Xavier's success are the more than thirty years of continuous administrative leadership provided by its premedical student adviser, Dr. J. W. Carmichael, and Dr. Norman Francis, president of the university, and the more than \$84 million and public and private grants received in just the five-year period from 1995–2000. Not only has Xavier sought out high school students interested in a career in medicine or other

sciences, but the college has provided programs to improve the quality of teachers of those subjects in New Orleans high schools. On entering Xavier all premed students take a prescribed core curriculum not only in science but also in nonscience subjects, a curriculum that is taught to meet national standards, all of which requires unprecedented cooperation from the faculty. In addition to the seventy-three Xavier students who went to medical school another eighty-seven went on to pursue graduate degree work in science-related fields (Stewart 2000, 22–26).

Significant programs for scholastic development such as Gateway and at Xavier University are crucial for the future success of affirmative action and other scientific fields because increasing the pool of students in the pipeline is the key. States and localities that have been responsible for providing inferior education for children in minority communities in the past should accept a legal and moral responsibility to do the right thing.

In 1996 the Association of American Medical Colleges leadership issued an important policy statement reaffirming their commitment to affirmative action recruitment programs as essential to desegregate and diversify our national physician manpower, and for the purposes of improving not only the education of all students, but also the quality of health care and medical research affecting all segments of our society (Nickens and Cohen 1996). Nathan Glazer (1999), in a reversal from his previous position, now maintains that for African Americans, racial group membership alone produces handicaps that result in lower test scores that underestimate their academic potential, which would be revealed if they gained access to superior education. U.S. academic leadership, he contends, is overwhelmingly committed to continue these programs, as they offer the best hope that our nation will ever become a color-blind society of equals.

MEASURING MERIT

Considerable misunderstanding exists about what test scores and grade point averages mean in the evaluation of medical school applicants in a given year. Let us look more closely at what happens.

In 1997 there were 43,020 applicants for 16,165 places in the entering classes of all of the 127 medical schools (AAMC 1998). This means that the chance of being accepted overall was 38 percent. What we are not told is how many of these applicants were well enough qualified to have been accepted. We must realize that almost every one of the 43,000 applicants believes he or she is qualified. Each of them has graduated from college with grade point averages and test scores that seemed to them, and perhaps to their premed faculty adviser, to be adequate. In fact the premed adviser

will usually have advised the student to apply to three different kinds of schools, probably four to which the student has a chance of being accepted, four to which the student almost certainly will be accepted, and four to which the student has only a slim chance of being admitted. Premed advisers have usually had some years of experience in discerning the behavior of different schools, and premed students have family members or friends who are eager to share their knowledge and conjectures about an applicant's chances at a given school.

Let us try to put ourselves in the position of members of an admissions committee. Recall again that while one out of three applicants is admitted, most often at least two of the three applicants could have been acceptable based on grade point average and scores and even interview and other subjective judgments of their potential. Admissions committees face a much more daunting challenge when it comes to the more highly selective and high-prestige medical schools. Even for schools not in the highest prestige category, the problem of selecting students is great indeed. For example in 1997 Boston University had 10,632 applicants for the 151 places in its freshman class, meaning that an applicant had on average a 1.4 percent chance of being accepted. Harvard had 3,708 applicants for 165 places (a 4.4 percent chance). Does this mean then the average applicant has a better chance of being accepted at Harvard than at BU? Not at all. Rather, it means that more students felt they had a chance for admission to BU than to Harvard and that Harvard's applicants had probably been more carefully self-selected and carefully advised. It would not be remarkable to find that as many as 98 percent of Harvard's and probably 85 percent of BU's applicants are qualified, based not only on grades and test scores but subjective evaluations of the applicant's future potential as a physician. The admissions committees at both Boston University and Harvard reject thousands of well-qualified applicants every year, and they must have a rationale for these decisions.

In 1997 Boston University received applications from 368 Black Americans, 140 men and 328 women; 19 were accepted, of whom 7 were men and 12 women. Of that group, 9 matriculated, 3 men and 6 women. Their first-year class was therefore 6 percent Black, but this could only have reflected an institutional commitment to have a Black presence in their entering class of 151. Almost certainly only a fraction of these students would have been admitted on the basis of test scores and grades alone and fewer still using a lottery system, quite aside from the fact that at both schools many qualified minority and nonminority students were not admitted. That same year Harvard had 216 Black applicants; 27 were accepted, of

whom 12 were men and 15 women. Of those 27 who were accepted, 15 chose to come to Harvard, 7 men and 8 women. Harvard's entering class of 165 therefore was 9.1 percent Black. My reading of this occurrence was that Harvard was expressing a continued leadership commitment to admit and graduate a significant number of Black physicians.

As future physicians, the majority of students will be practitioners. Some will be teachers, a few others will be researchers, while still others will be administrators, but almost all will combine several of these areas. Test scores and grades alone cannot substitute for more comprehensive indices, based on past life performance and interview behavior, of the kind of physician this candidate could become if given an opportunity to be a member of that class for four years.

Choosing the members of a new medical school class is a serious undertaking that carries long-standing social consequences. Society gives the medical profession what amounts almost to a monopoly right to care for those who are sick and injured or dying, and the right to inquire about the most personal and private details of a patient's life in the interest of assessing and treating their health problems. In carrying out their mission of health care, physicians are expected to be able to form rapid, helpful, personal communicating relationships with patients and members of their families. Physicians also are expected to be able to work collaboratively with other members of the health care team, nurses, social workers, lawyers, members of the news media, clergy, and other community leaders. All this and more is to be done with competence, compassion, integrity, humility and in a manner that instills hope and trust in others.

In making selections of the students who will make up the class, a conscious effort should be made to include members who represent all components of the community. Let us say that you are on the faculty of a medical school; you would certainly be concerned that no student be admitted who is not competent to handle the academic demands of the curriculum; otherwise the student will not graduate. If a student has gone to a first-rate college and graduated with a B average, has a medical college admission test score high enough to predict a 95 percent or higher chance of graduating, looks good in interviews, and has a life history of overcoming obstacles or of showing signs of resourcefulness, creativity, or leadership potential, the student is a good candidate for admission. The problem is that you have an embarrassment of riches. Perhaps as many as 80 percent or more of White applicants and Asian candidates meet those criteria. At least 40 percent to 50 percent of Black applicants have the same qualifications. However, since you have only 100 places in the entering class, but several thousand quali-

fied applicants, you must reject many qualified applicants. You will want to have a class that reflects equal and fair treatment of men and women, persons of differing religious and ethnic backgrounds, and social class and regional origins. You will be guided by considerations of the value of diversity within the class whose members will be with each other for four years and who in the future will be providing a crucial human service to all members of the public for the next fifty years or more.

In years past, most of the leading medical schools had an informal quota, admitting only an occasional Black student. The University of Michigan, from which I graduated as the only Black student in the class of 1946, had graduated one or two or three Black students almost every year since 1872, making it one of the schools with an enlightened admissions policy. Except for Howard and Meharry, the quota for Blacks in most schools nationwide was less than 1 percent. When I joined the Cornell faculty in 1968, I learned that from its beginning in 1898, Cornell had graduated only twelve blacks, six of whom had come from Africa rather than the United States. I also learned from discussions with physicians who had attended Cornell in earlier years that until the 1940s, Cornell had an unofficial quota of only about 5 percent Jews and 10 percent Catholics in its first-year class. Each incoming class also contained between 5 percent and 10 percent women. Similar admission patterns were practiced in almost all of the nation's medical schools.

All of this changed gradually and then changed more rapidly following World War II. Jewish applicants no longer are held to a low quota and now comprise large, and unpublicized, portions of all medical school classes. The same schools also opened up silently to Catholics. These gender- and religious-based restrictions had nothing to do with merit or demerit, but simply reflected general American institutional prejudice and bigotry in earlier years. Medical schools never admitted that they had a quota for limiting the numbers of Jews, Catholics, or women, although by law Blacks were excluded from southern and some border states' schools. We have observed the opening up of medical schools for women who went from 8.7 percent of first-year students in 1968 to 42.6 percent in 1997, again a favorable change that will bring untold benefits to our entire nation. All of these demographic and more democratic changes in the nation's medical workforce are now perceived as fair. The Women's Medical College of Pennsylvania became coeducational and changed its name to the Medical College of Pennsylvania when its mission began to be carried out in all medical schools.

Ludmerer explains that the low percentage of women in medicine,

which for decades had been stable at between 6 and 7 percent, compared favorably with the low percentages in such fields as law or engineering, both at the 2 percent level. In the late 1960s women began to enter most of these professions from which they had been informally excluded, primarily as a result of the women's movement for civil rights, as well as legal protection of these rights by enactment of the 1972 Title IX of the Higher Education Amendments banning sex discrimination in education programs receiving federal funds. Once women were admitted their medical school presence did not plateau in the mid-1970s, as it did for minority students, because the educational pipeline for women was as strong as it was for men and the vast majority of women admitted also were White (Ludmerer 1999, 256–57).

A profile of all the entering class of 1996 reveals that 34.5 percent of the 46,968 applicants to medical school were accepted. On average they made about a dozen applications, and they received almost two acceptances each, although this varies by subgroup to which they belong. The acceptance rate for Blacks was 34.7 percent, for Whites 37.8 percent, for women 34.5 percent, for Asians 32.6 percent. The grade point average for the groups mentioned above were Blacks 3.1 in science subjects and 3.4 in all other subjects; for Whites, the science grade point average was 3.5 and 3.6 for all other subjects; for Asians 3.6 for science subjects and 3.7 for other subjects. You can be certain that some students with grade point averages of 3.9 or even 4.0 were rejected because they were less promising candidates for other reasons. Wide differences were found in the Medical College Admission Test scores: verbal reasoning for Blacks, 7.8 on a scale up to 15, for Whites, 9.9, for Asians, 9.6; physical sciences: Blacks, 7.6, Whites, 10.1, Asians, 10.7; biological sciences: Black, 7.9, White, 10.2, Asian, 10.7 (AAMC 1998).

The experience of most medical schools reveals that a score of 7.0 on a fifteen-point scale is high enough to predict a 95 percent or higher graduation rate, especially if the student has graduated from a first-rate college with a grade point average of B or better. Scores of 13, 14, or 15 do not forecast graduate rates any better. Prior to 1977 an older medical college admission test had been used for twenty-six years. Scores on that test ranged up to 800. The four subscales for the old MCAT were Verbal, Quantitative, General Information, and Science. The proportion of students dismissed or repeating the first year is given in 50-point ranges of subscale scores. For those in the 450–99 range, the failure rate ranged from 8 percent (Quantitative) to a low of 4 percent (Verbal). The 500–49 range went from a high of 5 percent (Quantitative) to 3 percent (Verbal and General Information).

The 550–99 range went from a high of 3 percent (in Verbal, Quantitative, and General Information) to a low of 2 percent (Science). In the 600–49 range, the high of 3 percent (Quantitative) was seen with a low of 2 percent in Verbal, General Information, and Science. For the higher ranges 650–99 and 700–99 the same 2 percent failure rate was uniformly found on all four subscales. Essentially those scoring in the 550–99 range had no more than a 2 percent to 3 percent failure rate, which was similar to that of those scoring higher, up to 799. Admissions committees in various geographic areas were, in consultation with other faculty, free to decide the risk level they could tolerate, given the strength of their total applicant pool. (Data on MCAT scores are from Appendix G-7 in Carnegie Council 1977 [237], which is based on AAMC data.) Careful studies showed that students scoring 450 to 500 had graduation rates of 97 percent to 98 percent, and that those who scored 600 to 800 did not have higher success. In other words, beyond a certain criterion score, the numbers have no significant predictive power in graduation rates. A few students will drop out for reasons having nothing to do with cognitive ability as measured by admissions test scores. In my opinion, the scores do predict which students have had the benefit of high-quality schooling and competition with other bright students. Parental characteristics by race were as follows: Occupation: professional or managerial category for fathers of Blacks, was 51.5 percent, Whites in that category 61.4 percent, Asian 60.1 percent. Father having a college degree: Blacks, 14.1 percent, Whites, 18.7 percent, Asian, 16.6 percent. Mother having a college degree: Blacks, 15.0 percent, Whites, 24.1 percent, Asians, 31.7 percent. Median parental income: Blacks, \$50,000, Whites, \$75,000, Asians, \$70,000. Fathers who were physicians: Blacks, 1.5 percent, Whites, 1.8 percent, Asians, 10.1 percent.

Despite obviously different life circumstances of Blacks, lower grade point averages and even relatively lower MCAT scores provide the basis for legal challenge to their being admitted fairly. This is the crux of the argument against race-sensitive admissions.

AFFIRMATIVE ACTION IN AMERICAN HIGHER EDUCATION

The Affirmative Action admission of Black Americans to the nation's medical schools has been a part of the larger movement to consider race as one of the factors favoring admission of qualified candidates to colleges and universities from which they were largely excluded for the past four hundred years. Americans are deeply divided over this issue, and until recently the debate has been little guided by hard evidence. In 1998, therefore, the

issue was greatly clarified by the publication of the long-term consequences of considering race in college and university admissions. William Bowen, president of the Mellon Foundation and former president of Princeton University, and Derek Bok, former president of Harvard University and former dean of the Harvard Law School, drew on a huge database containing the admissions and transcript records and subsequent occupational histories of more than eighty thousand undergraduate students who matriculated at twenty-eight selective colleges and universities from 1951 to 1989 (Bowen and Bok 1998). The aim of the study was to obtain a long-term view of differences between Black and White students from high school through undergraduate, graduate, and professional school, and into their occupational and community life. The authors picked the most selective research universities and liberal arts colleges because they are the schools that have been attacked for presumably admitting less qualified Blacks while rejecting more highly qualified Whites. The Bowen-Bok calculations showed that if admissions had been based entirely on grades and test scores, Black enrollment at these colleges would drop by 50 to 70 percent and from 7 percent to 2 percent of total enrollment (51).

Critics had surmised that Black students would become demoralized finding themselves competing with White students who had higher grades and scores, and that the Black students would be more successful in less competitive colleges. However, Bowen and Bok found that these Black students with the lowest SAT scores had higher graduation rates than Blacks who attended less competitive colleges. A striking finding was that the average SAT scores of Black entrants to the most selective schools in 1989 were higher than the average of all matriculants in the same institutions in 1951, an observation that middle-aged and elderly alumni of those colleges should note. In other words, test scores of Whites have steadily increased from one generation to the next (30).

Despite differences in test scores on admission, both Blacks and Whites highly valued their experience studying and living together during their college years. How well the Black students performed after college also was very impressive. Forty percent went on to earn graduate or professional school degrees, compared with 37 percent of White students who entered the 28 colleges in 1976. From all colleges nationally, only 8 percent of Blacks and 12 percent of Whites go on to attain doctoral or professional degrees. A further breakdown of the Bowen-Bok graduates from the group of elite schools showed that for the 1976 entering cohort, 14 percent of Blacks and 11 percent of Whites received law degrees, 11 percent of Blacks and 8 percent of Whites received medical degrees, 13 percent of Blacks and

13 percent of Whites got business degrees, and 4 percent of Blacks and 7 percent of Whites were awarded Ph.D. degrees (100). Bowen and Bok constructed a profile of 700 Black students who matriculated in 1976 but who would have been rejected under a color-blind standard (281). More than 225 went on to attain professional degrees or doctorates, about 70 are now physicians and 60 are lawyers, 125 are business executives, more than 300 are leaders in civic activities. The average earnings of the group exceed \$71,000, which, according to census data, is at least 75 percent more than Blacks who hold bachelor's degrees in their age cohort but not as high as their White former classmates. Two-thirds of this group considered themselves "very satisfied" with their undergraduate years. However, the Black students tended to earn slightly lower grades than Whites with the same SAT scores.

Some have suggested that if these same highly selective colleges had admitted students from low-income families by preference, without regard to race, the same result would be achieved and with less adverse public opinion. Bowen and Bok disagree. Although 50 percent of American Black families with children sixteen to eighteen years old fall into the lowest of three socioeconomic categories (neither parent has a college degree and family income is below \$22,000), only 14 percent of Black students in their study were from such families. While only 3 percent of all Black families are in the highest category (defined as at least one parent being a college graduate and family income is more than \$70,000), 15 percent of Black students in this study were from such families. The authors point out that in absolute numbers there would be six times as many Whites as Black students in the low-income pool (51). Further, students from extremely impoverished family backgrounds of any race are usually unable to survive in a highly competitive college environment.

Still others maintain that race-sensitive admissions violate the rights of innocent Whites who are rejected despite their better credentials as shown by grades and test scores. Such injury is small indeed, as Bowen and Bok estimate, inasmuch as if no Blacks were admitted to any of the 28 elite colleges in the study, the chances of admission for any individual White applicant would at most increase from 25 percent to 26.5 percent because there are so many rejected White candidates with the same grades and test scores. On the other hand, the mission of our great universities is not to preserve and solidify the continued exclusion of Black Americans from positions of power and leadership. As Ronald Dworkin pointed out in his review of Bowen and Bok's book (1998), our schools "have traditionally aimed to help improve the collective life of the community, not just by protecting and

enhancing its culture and science, or improving its medicine, commerce and agriculture, but by helping to make that collective life more just and harmonious . . . the continuity and debilitating segregation of the United States by race, class, occupation and status is an enemy of both justice and harmony. . . . Affirmative action has begun to invade that segregation in ways no other program or policy probably could" (100–102).

THE NEED FOR AFFIRMATIVE ACTION AT ELEMENTARY AND HIGH SCHOOL LEVELS

African American children start their education with significant socioeconomic disadvantages compared with European American children: twice as many are low-birthweight babies (10.4 percent v 5.1 percent); nearly 44 percent live in households with annual incomes of less than ten thousand dollars, compared with 9.5 percent European Americans; 66 percent live in single-parent homes, compared with 15.8 percent European Americans; and fewer African American parents have four or more years of high school (68.7 versus 77.6 percent) (*New York Public Library* 1999, 203). Tests of developmental abilities of preschool children show that African Americans score equally well on motor and social and memory scales but score slightly less well on verbal scales. However, African American children begin to lag behind during grade school, and the learning achievement gap remains constant or widens from then on.

The successful outcome in the Supreme Court case of *Brown v. Board of Education* in 1954 put an end to legalized segregated public education. The court ruled that racially segregated schools, legalized in the 1896 Supreme Court *Plessy v. Ferguson* case, had to be ended because they violated the equal protection rights of Black children, who were entitled to receive an equal quality of education that was not possible under conditions of forced segregation. Unfortunately, the years since 1954 have witnessed more segregated school experiences for Black children. Residential segregation has increased since the 1950s, carrying with it not only segregated neighborhoods both in cities and suburbs, but also de facto racially segregated schools (Orfield and Eaton 1996, 53–72; Meier, Stewart, and Eagland 1989, 136–49).

These developments have led many African American leaders to question the wisdom of continuing to seek integration from White Americans who do not want to live with them as neighbors or to have their children attend their schools (Steinberg 1989, 253–302; O. Patterson 1997, 171–203; Allen and Jewell 1995).

While I think it is too early to give up on the goal of achieving racially

integrated neighborhoods, it seems obvious that we must either make headway toward that aim or expect an increasingly angry and violent demand for a genuinely separate and equal African American nation within a nation (Canty 1969, 59–73; Klinker and Smith 1999, 317–51).

Amid all this noisy rancor and polarized rhetoric, we may not be addressing the main problem facing us as a single nation. While many Whites feel secure that their children are receiving an education that is relatively superior to what is offered to Blacks, we have serious deficits in the quality of education received by all American children. The problem is spelled in graphic detail in an important book *The State of Americans* (Ceci 1996). Both thirteen-year-olds and seventeen-year-olds scored slightly higher on mathematics and reading tests in 1990 than in 1971 performance, but nearly all of the upward gain of the past twenty years has been due to the extremely large gains made by Black thirteen- and seventeen-year-olds. Changes in the test scores of White students over this same period have been minimal. In 1971 Black students averaged 35 to 40 percentage points below White students; by 1990 the gap has been reduced to 17 to 25 points. Ceci believes that the gains for Black children may be due to the improving educational achievement of Black parents, who now graduate from high school at almost the same rate as Whites, the fact that increasing numbers of Blacks are attending desegregated colleges, and that the average size of nonwelfare families has dropped dramatically in the past twenty years.

Most disturbing are his data on international comparisons of American student test scores in mathematics and science. American fourth graders have gone from the middle of a group of seventeen developed countries to near the bottom. They ranked fourth in 1970 but had dropped to twelfth by the mid-1980s. The picture for American eighth graders is even worse: they were near the bottom in 1970 (fifteenth out of seventeen) and have remained there in the mid-1980s. American schools report only 15 percent of high school seniors taking calculus, although more than half of high school seniors in England and Wales, Israel, Scotland, and Japan take this course. U.S. calculus scores are lowest on international tests: the average score is “less than half that of the children of its major trading partners” (Ceci 1996, 198). In international comparisons our best students do poorly: “the top 10% and top 25% of American students tend to be nearer the achievement levels of Italy and Thailand than to Japan, Sweden and England” (200). Ceci speculates that one main reason for their performance is American children spend much less time in learning activity inside and outside the classroom: for example 21 percent of our nine-year-olds spend more than

five hours per weekday watching television, “far more than the children of U.S. trading partners” (201).

Diane Ravitch (1995, 177–86) gives an authoritative presentation of the issues surrounding our failure to develop a national commitment to provide all American children a high-quality education that will make us competitive with the rest of the developed world. First and foremost, most parents are satisfied with the education their children receive, even though increasingly it has become a high-priority political item. Problems arise because the federal government supplies only about 7 percent of the money spent to educate our children, with the rest provided by localities and states that insist on local control of school policy. Because there is fear and mistrust of federal government control of education policy, Congress fails to arrive at bipartisan programs to improve the educational performance of our schools. There is no political consensus that we should have a national standard curriculum and require all children in all parts of the country to be able to pass uniform proficiency tests. Until this is done, there is little likelihood that equal educational opportunity will become a fact in American life. Only then, however, will we be able to demonstrate that we can educate our children as well as other developed nations currently are doing. We have a firm belief that only a fraction of our children are bright by innate good fortune, and that only these children should be placed on a special track and provided a high level of schooling. Ravitch and others point out that this is not a commonly accepted view in many industrialized countries, which assume that all children should be challenged to learn even difficult subjects. Only following this more inclusive principle will it be possible to maximize the more complete potential of a greater proportion of children. Ravitch also points out that by and large, American parents and children are satisfied with the amount of time and hard work their children spend on the academic mission of schools. Our future ability to compete with the next generation of this global village, in this new information age, will be determined largely by our making a national commitment to educational excellence and equality.

THE FUTURE OF COLOR CASTE

The gaps between Black and White test scores, family income (and the much larger gap in wealth), health and longevity are all reflections of the enduring system of color caste, almost 100 years after Black people were freed from slavery, which had lasted 250 years. Over the course of the past century all Americans, Black and White, have experienced improvements in health and longevity, in intelligence test scores, and in so-

cioeconomic status. Moreover, the gap between Blacks and Whites has become more narrow in each of the areas mentioned, but our nation will face a serious challenge unless we begin to educate minority students more "equally with White students, particularly in the science-based fields" (Hamburg 1992, 298).

By the year 2020 nearly half of all school-age children will be non-White; in the 1990s minorities already were the majority of primary and secondary school students in twenty-three of the twenty-five largest cities (Hamburg 1992, 297). Census 2000 showed a total population of 281,426,906, a 13.2 percent increase over Census 1990. Blacks identifying as Black only increased by 4.7 million, or 15.6 percent since 1990, and adding those identifying as Black and at least one other race would bring the increase to 6.4 million, or a 21.5 percent increase. The total Black population is 36.4 million, or 12.9 percent of the U.S. total population. Census 2000 shows Hispanic or Latino population of 35.3 million, representing a 57.9 percent increase over 1990, close to parity with Black Americans, or 12.5 percent of the total U.S. population (U.S. Dept. of Commerce 2001). As I pointed out earlier, demographic projections are that the Black population as of the year 2030 will have doubled the 1990 figure and will be 62 million. If we do not develop the full potential of these young people, we will be inviting untold misery for the entire nation.

America's technologically educated workforce, Hamburg reminds us, has traditionally come from a small fraction of the population, about 6 percent, the "White, male, college-educated population," yet "the traditional white male source of scientists and engineers is inadequate." Our nation must accept the challenge of educating previously excluded minority groups and women, not only out of concerns for equity and fairness, but also to protect our "economic vitality, democratic civility, and military security." He mentions the sweeping changes in educational opportunity necessary to bring about more equal educational opportunity for minority groups, especially Blacks. These educational interventions should cover the entire life cycle from prenatal, postnatal, preschool, and school-age years, and into adulthood. Very young children especially without adequate supportive families, would require the equivalence of surrogate parenting. Schooling should cover a core curriculum meeting national standards and norms, with a longer school day, and year-round schooling involving parent-teacher community and church leadership and teamwork.

But education should also be combined with equalization of job opportunity, as Robert Solow has pointed out (1998). He argues that welfare as we know it must be changed, but not in the inadequate manner of the

1996 Welfare Reform Act. Solow maintains that simply putting people off the welfare rolls without giving them jobs increases the unemployment rate of the lowest-paid workers and may leave the children of young mothers with less developmental support. Jobs should be provided either in the private sector or by the government, as well as high-quality child care for working mothers. Roemer, agreeing with Solow and the others, points out that genuine welfare reform should also include compensatory educational opportunity for adults as well as school-age children, and that such a program would be very expensive. It would require at least 6.5 percent of the nation's gross national product in contrast to the 2.4 percent currently spent. Politicians favor welfare reform but do not support the increased taxation it would demand. A guaranteed job would of course be a benefit for all Americans, making it possible for all to have increased feelings of self-respect, dignity, and the ability to become productive citizens.

Welfare reform should not only carry with it increased governmental expenditures, it should also be obligatory that welfare recipients meet standards of social functioning in areas of work, education, and civic responsibility. According to Lawrence Meade (1986, 1997), a political scientist who has carefully analyzed this problem, even though this can fairly be described as benign paternalism, which runs counter both to liberal and conservative frames of mind, it is a federal policy more likely to advance the integration of the so called "underclass" into mainstream American society. We must set standards but also make it possible for people to meet them. I agree with Glenn Loury (1998) that a combination of increased benefits along with increased responsibility would be not only productive but well received by welfare recipients.

Welfare reform should also include programs to interrupt the cycle of welfare dependence from one generation to the next. Daniels, Kennedy, and Kawachi (1999) cite as one example the twenty-seven-year study of a high-quality early childhood developmental program for children three to five years old in a low-income neighborhood in Ypsilanti, Michigan (Schweinhart, Barnes, and Weikart 1993). Compared to a control group, those in the intervention group had completed more schooling by age twenty-seven and were more likely to be employed, to own a home, and to be married with children. They also had experienced fewer criminal problems and teenage pregnancies and were less likely to have mental health problems.

Other demonstration programs with relatively low-intensity intervention have shown great promise. In one program, pregnant single teenage mothers were visited once a month during pregnancy, and these monthly

visits continued until the children were two years old. During the ninety-minute interviews the visiting nurse followed a structured protocol covering such items as the developmental progress of the infant, advice on contraception and avoidance of subsequent pregnancy, advantages of involving the putative father and relatives, building a friendship support system, school completion and job training, and use of community health and social services. Fifteen years later, extensive follow-up showed considerably higher social function for these young mothers and their children. These findings clearly demonstrated more successful social functioning in comparison with a control group. This sample of predominantly White teenage mothers in Elmira County of upstate New York is currently being replicated with a 1990 sample of Black single mothers in Memphis who have been followed already for more than ten years with favorable results (Olds et al. 1997; Olds et al. 1998; Kitzman et al. 1997; Earls 1998; Loury 1998).

I believe that our nation will continue to equalize opportunity for all, and that the test case will be the measure of equality achieved by Black Americans. With their increasing numbers Blacks will become either more productive members of mainstream society or they will become progressively isolated, alienated, and forced into retaliatory and self-defeating behavior. As a nation we need them more as college graduates than as prisoners. It will probably cost much less, financially and in every other way, to choose greater opportunity rather than oppression.

EQUALIZING THE HEALTH STATUS OF BLACK AMERICANS

Byrd and Clayton (2000) have given us the most comprehensive history of race, medicine, and health care in the United States. What they refer to as the “Second Reconstruction in Black Health” lasted from 1965 to 1975, a part of the civil rights movement: desegregation of hospitals through court rulings, civil rights laws outlawing discrimination in government-funded health programs, the passage of Medicare and Medicaid, removing financial barriers to health care, neighborhood health centers in underserved communities, and affirmative action admission to medical school and postgraduate training. Within this ten-year period African American health improved by “every measure of health status, utilization and outcome.” Stagnation occurred after 1975, and relative and/or absolute decline (compared to Whites) began after 1980. These improvements still left remaining a significant amount of race-based health disparities.

In November 2000 President Clinton signed into law legislation elevating the status of the Office of Research on Minority Health to that of

a Center in the National Institutes of Health and provided 130 million dollars for the new center, nearly 40 million dollars a year more than previous funding. Additionally, Congress allocated funds for the Institute of Medicine to conduct a study on racial bias in medicine, which was scheduled to be completed in early 2002. A national task force has been set up to coordinate efforts of the Department of Human Services, the American Public Health Association, the AMA, and National Medical Association to bring about positive change in addition to study. There are indications that the initiative to remove racial health status disparities will be continued despite the change from Democratic to Republican leadership (Dirks 2001).

As David R. Williams and Toni D. Rucker (2000) point out, "Effectively addressing health care disparities will require comprehensive efforts by multiple sectors of society to address large inequities in major societal institutions," including "concerted societal-wide efforts to confront and eliminate discrimination in education, employment, housing, criminal justice and other areas of society which will improve the socioeconomic status . . . of disadvantaged minority populations and indirectly provide them greater access to medical care . . . as a fundamental right of citizenship" (33). It is my own opinion that chances are slim for a straightforward political commitment at federal, state, and local levels to equalize the health care or health status specifically for Blacks. As Clayton and Byrd (2001) state, extreme and persistent race-based health disparities exist because "public policy and funding have traditionally followed the concerns of the majority (White) population and not necessarily the public health problems of the nation's underserved and disenfranchised." They note that the mortality rate ratio is at least 1.5 times greater for Blacks than Whites in eight of the fifteen leading causes of death. These Black-White ratios lessened between 1989 and 1996 in some areas like homicide (from 6.6 to 6.2), kidney disease (3.1 to 2.6), chronic liver disease and cirrhosis (1.7 to 1.3), and cardiovascular disease (1.89 to 1.8). There was no improvement from 1989 to 1996 in the disease categories of cancer, a death ratio of 1.3, or pneumonia and influenza, which remained stable at 1.5. Deterioration or widening of mortality ratios from 1989 to 1996 were found in HIV-AIDS (from 3.3 to 5.8), septicemia (2.7 to 2.8), diabetes mellitus (2.3 to 2.4), heart disease (1.4 to 1.5), and perinatal conditions (2.3 to 2.4).

It should be apparent, from these movements and change, that a massive intervention would be required to eliminate these health status disparities. We should also note, however, that these same authors pointed out that during the decade of 1965 to 1975 the civil rights movement was accompanied by sweeping and overall improvements in the health of

Black Americans relative to Whites and relative to anything experienced earlier in American history. What strikes me as the crucial factor is that it was during that same 1965–75 decade that we experienced dramatic improvements in civil rights for women, an impressive war on poverty and actual reduction in numbers of impoverished Americans in general, and improved civil rights for the handicapped and other disadvantaged Americans. In my view major improvements for Blacks can occur only when there is simultaneous improvements for other constituencies. What are the prospects therefore for a revival of these positive social changes?

REFRAMING THE PROBLEM: AFFIRMATIVE ACTION FOR ALL AMERICANS

It is my opinion that as a nation we must become aware that we have a national health status problem, as well as problems in our delivery of the whole array of human services and a need to improve our general social welfare and health. In speeches of our national leaders, and in presentation by the media, the American public is kept continuously aware of our economic health as shown by such indicators as the gross domestic product, the stock market, the index of leading economic indicators, the balance of trade, the inflation rate, the consumer confidence level, and other such measures. All of these barometers tell us how we are doing economically, warn of the threat of economic downturn or recession, and give authority to the Federal Reserve to raise or lower interest rates to prevent serious damage to our economic welfare. Miringoff and Miringoff (1999) make the case that we need similar mechanisms to monitor, forecast, and modulate the social health of the nation. While we lead the world in monitoring our economy, we lag behind other developed nations in monitoring our social health. Beginning in the 1970s Great Britain and seventeen other industrialized nations have issued annual surveys focusing on health, housing, education, safety, employment, and access to services, stressing behavior and concrete experience of their citizenry rather than just documenting their opinion and attitudes. In this country, while we are relatively weak or inactive in reporting social indicators at the national level, many localities since the 1970s have established projects to monitor and report on the quality of community life. With major foundation support, the Miringoffs for the past twelve years have headed the Fordham Institute for Innovation in Social Policy, and have reported overall U.S. and state scores on an index of social health. In the period 1970–96 their indicators have shown positive and negative changes within our nation, how the states compare with each other and also how we perform relative to other nations.

For example in the 1970–96 period, four national indicators improved: infant mortality, high school dropouts, poverty for those over sixty-five years of age, and life expectancy for those over sixty-five. However, seven indicators showed worsening performance: child abuse, child poverty, teenage suicide, number of health care uninsured, average weekly wages, income inequality, and violent crime. Another six indicators showed variable performance: teenage drug use, teenage births, alcohol-related traffic fatalities, affordable housing, and employment. Our political leadership is not held accountable for the state of our social health, nor are we given by the media anything like a daily “weather report, a sports report, an economic report, a business report and a political report. What is missing . . . is the idea of a ‘social report’” (Miringoff and Miringoff 1999, 172). Miringoff and Miringoff go on to say that “in a democracy, problems generally are not addressed until they are recognized and understood by the public. Yet many social conditions have worsened for a generation without significant public knowledge.”

Even less is the public aware of how unfavorably our social health compares with other nations. Our unemployment rate was in 1996 good, the second lowest of the ten nations with acceptable data, but we had the highest rate of child poverty among Western industrialized nations, ranking seventeenth of seventeen; we were eighteenth out of eighteen on income inequality, and near the bottom of the list in indicators such as elderly poverty, high school dropouts, infant mortality, life expectancy, teenage births, wages, youth homicide, and youth suicide. Raphael (2000) points out that despite spending a greater percentage of gross domestic product, 13.5 percent, on health care than any other industrialized nation, “for nearly all available outcome measures, the United States ranked near the bottom of the OECD countries in 1996 and the rate of improvement for most of the indicators has been slower than the median OECD Country. . . . Among the 29 Organization for Economic Corporation and Development nations, USA life expectancy ranked nineteenth for females and twenty-second for males” (404).

While there is a need to develop and implement programs to bring Black Americans up to an acceptable standard of health, we should accept the challenge to do the same for all Americans. Raphael (2000), in a review of the emerging literature on the social determinants of health, maintains that it is the growing economic inequality within the United States that affects health directly by creating greater poverty and indirectly by weakening communal social structures that support social and health services, and by decreasing social cohesion and civil commitment (427).

While it is true that health differences in the United States are related to race, this obscures the fact that even larger differences are related to levels of income class, which receives relatively little attention. Low-income American families “are at a distinct disadvantage compared with similarly situated families in other nations” (406). Beyond a consideration of the importance of lifestyle and community support structures in protecting health, a greater focus is required on such basic economic factors as the effects of globalization on labor demand and changes in tax structure and funding of social welfare programs in the United States. In other words, there are fundamental limitations to addressing racial and ethnic health inequalities rather than our national health status by comparison with other developed nations.

Starfield (2000) notes that the United States ranks twelfth among a group of thirteen of the most developed nations on health indices covering the life cycle from infancy through the elderly years. Removing U.S. Blacks from our national health statistics does not improve our cross-national comparative rank. In the United States those states with the most unequal income distributions “invest less in public education, have larger uninsured populations, and spend less on safety nets. . . . Even when controlling for median income, income inequality explains about 40 percent of the between-state variation in the percentage of children in the fourth grade who fall below the basic reading level. Similarly, strong associations are seen in the percentage of high school dropout rates” (Daniels, Kennedy, and Kawachi 1999, 223).

Daniels, Kennedy, and Kawachi (1999) conclude that we should consider such disparities “inequalities when they are avoidable, unnecessary, and unfair” (225). When age, gender, race, and ethnic differences in health status exist that are “independent of socioeconomic differences,” they “raise distinct questions about equity of justice.” Following John Rawls (1971), these authors conclude that health inequities cannot be overcome except by paying attention to the primary social goods all persons require in addition to health care, including “liberty, powers, opportunities, income and wealth, and the social bases of self-respect” (229).

There are two ways to address the issue of how compensation should be made to Black Americans for unpaid labor during almost 250 years of chattel slavery, and their subsequent exclusion from asset-building governmental policies that were made available to Whites. Randall Robinson (2000) has been joined by other prominent Black lawyers who have filed suit against the U.S. government and several corporations to win financial reparations to make up for assets that should be restored to Black people

here. It is Robinson's position that this is a claim that should be made even if the chance for success is slim, because it is the right thing to do, especially since we live under an adversarial system of justice and should use any legal means to correct this long-standing injustice. In my view there is a basic flaw in the argument for reparations: slavery was immoral indeed, but it was legal and governmentally protected. Moreover the institution of slavery not only impoverished Blacks, it diminished and stunted the development of our nation as a whole in ways that still survive in our American way of life. Both Black and White Americans should be freed from this hand of the dead past.

Another and better approach to achieve compensation for many generations of unpaid labor was proposed by Martin Luther King in *Why We Can't Wait* (1963). It has been a general government policy to reward veterans returning from war with benefits they might have lost during years of service, such as the GI Bill of Rights following World War II. Benefits included subsidies to finance their continued education, extra points on civil service examinations, lower interest rates to purchase a home or to launch a business, medical care and long-term financial grants if they had suffered physical or emotional disability. King believed that, while no amount of money could adequately pay for the many years of exploitation and humiliation during slavery, there is a long tradition in common law that remedy should be made when human beings have been financially damaged. He thought this country should launch a broad-based "Bill of Rights for the Disadvantaged," patterned on the GI Bill of Rights. However, King believed this massive social transfer should be paid not only to Blacks but also to poor Whites, especially in the South, because their poverty largely resulted from the fact that their labor "was cheapened by the involuntary servitude of the Black man" (1963, 138). He went on to say that White workers even now are pacified by being allowed to feel superior and thereby distanced from Black workers.

The nation would have much to gain by a determined effort to eliminate poverty, especially, and of the highest priority, to eliminate child poverty. During the past generation, Americans, Black and White, have experienced a breakdown of the two-parent family: in 1950 only 17 percent of Blacks and 5 percent of Whites lived in households headed by women, but in 1990 we had 56 percent of Blacks and 17 percent of Whites with absent fathers. Hacker points out also that the 9.9:1 ratio of the rate of unmarried Black mothers to unmarried White mothers in 1950 (16.8 percent Black to 1.7 percent White), was reduced in 1988 to a ratio of 4.3 to 1 because the increase for White women was greater than that for Blacks (1992, 74).

Hambroke et al. (1996, 180–81) point out that in 1993 the proportion in poverty of young children of White single-parent mothers, (43 percent), is “about the same as had already been reached by Black single-parent mothers in the late 1960s” (184). Forces producing poverty are not static but rather a dynamic system: “some groups in society are more vulnerable to these escalating forces, others less so, but all are moving in the same direction” (184). A family is said to be in a state of deep poverty if their family income is 50 percent below the poverty line—only half of what a family needs for basic expenses like food, housing and other living costs. The percentage of White children under age six in deep poverty in 1993 was 7.7 percent, whereas for Black children under age six, about 33 percent live in deep poverty. “Over the past two decades, the percentage of children living in such deep poverty has more than doubled, from 1.1 million in 1975 to 2.8 million in 1994. Forty-seven percent of all young children are in poverty as compared with a third, 32 percent, in 1975, just before the rapid decline in economic growth” (181). We should bear in mind that although the percentages of Black children are more than four times higher, the actual numbers of White children living in deep poverty, exceeds the Black number: of the 17.1 million children in the United States who are under six years of age, 80 percent are White, 16 percent Black.

While it is true in my opinion that disparities between Blacks and Whites in the field of health should be identified and monitored and that special efforts should be launched to remove them, it should be kept in mind that since the 1960s we have not heard a call for our nation to renew a general war on poverty. White poverty remains essentially invisible. There has been a largely successful political strategy of labeling increased federal governmental spending for human services as a plan to advance the cause of African Americans at the expense of the White middle-class taxpayers. As Klinker and Smith summarize the present situation: the greatest impediments to greater social and ethnic equality are to be found in the resurgence of arguments for state and local governments instead of national government initiatives, increased calls for “color blind” governmental action, of personal initiatives as solutions, resurgent “scientific racism” such as the Bell curve propaganda, decline in civil rights law enforcement, and diminished enthusiasm for a racially integrated nation. On the other hand, there are strong forces to continue genuine removal of ethnic disparities, such as support for civil rights law enforcement and for ending racial profiling, and a beginning awareness that economic inequality is a major threat to our cohesion as a national community. Klinker and Smith also believe that specific means must be found to reform the criminal justice system, which has

devastated so many young Black men. Another positive force would be the reinstatement of the military draft on an egalitarian basis, to require all young Americans of different racial, ethnic, and social class backgrounds to learn to work with, and to develop friendships with, persons of different backgrounds.

A HOPEFUL FORECAST

Robert W. Fogel, the 1993 Nobel Prize winner in economics, believes it is altogether feasible that inequality nationally and worldwide be reduced over the long term. The record of the twentieth century “contrasts sharply with that of the two preceding centuries. In every measure that we have bearings on the standard of living, such as real income, homelessness, life expectancy, and height, the gains of the lower classes have been greater than those experienced by the population as a whole, whose overall standard of living has also improved” (2000, 143). Economists use the Gini ratio to measure income inequality (zero is perfect equality and 1.0 represents maximum inequality). Data for England is available to show that the Gini ratio was 0.65 near the beginning of the eighteenth century, 0.55 beginning the twentieth century, and 0.32 in 1973, when it bottomed out in England and “also in the United States and other rich nations” (143).

A striking example is shown by life expectancy improvement: in 1875 the British upper class lived seventeen years longer than the population as a whole. Today, the “advantage of the richest classes over the poorest is only about two years. Thus, about seven-eighths of the social gap in longevity has disappeared.” Longevity for the lower classes went from forty-one years at birth in 1875 to seventy-five years today—and again there are roughly comparable figures for the United States. “Indeed, there has been a larger increase in life expectancy during the past century than there was during the previous 200,000 years. If anything sets our century apart from the past, it is this huge increase in the longevity of the lower classes” (Fogel 2000, 143).

Average height and weight, which are measures of improving nutrition, have shown similar changes. Reductions in homelessness tell a similar story of improvement over the long term, but the United States in recent decades has seen an increase of homelessness among the most vulnerable segments of our population: mentally ill persons released from hospitals to communities with inadequately funded programs to meet their needs; other homeless people are “chronically poor, young, and inadequately trained for the current job market” (Fogel 2000, 145).

However, Fogel notes that despite the sharp rise in incomes, “especially

at the low end of the income distribution, the moral crisis of the cities remains unresolved . . . such problems as drug addiction, alcoholism, births to unmarried teenage girls, rape, the battery of women and children, broken families, violent teenage death, and crime are generally more severe today than they were a century ago" (172).

Fogel is convinced that simply gaining more income or possessions does not automatically increase morality, virtue, or spiritual growth, as can be seen in current observation of all social classes. When he speaks of the severe maldistribution of spiritual resources, he is not referring to formal religious or church membership but rather to such psychological resources as self-realization (a feeling of developing one's full potential as a person), a sense of purpose, a vision of opportunity, a sense of the mainstream of work and life, a strong family ethic, a capacity to engage with diverse groups, a work ethic, a sense of discipline, self-esteem (2000, 204–5). In the United States, as in other rich countries, overeating is a greater problem than undereating. The "opportunities to fulfill one's potential are more unequally distributed than food, consumer durables, or health care" (178).

Fogel is optimistic that the next six decades will see further reductions in the unequal distributions of both material and spiritual resources, fueled by such factors as the pressure for improved educational attainment, the world demand for more skills and professional manpower, and increasing political power of ethnic minorities and women (2000, 238). However he anticipates resistance to the development of a smooth transition from "a governing minority that is predominantly White and Protestant to a governing majority that is nonwhite and nonProtestant, one that does not sacrifice fundamental egalitarian ethical, political, social, and economic principles" (239–40).

SUMMARY

My concluding opinion is that affirmative action at all levels of education, from preschool through university, represents the best policy and program to build a strong, single, and ethnically integrated nation. As others have pointed out, these past thirty years of affirmative action admissions to the most prestigious colleges, universities, and professional schools have produced a strong African American middle class that is providing leadership not only for Black people but for the benefit of all Americans. Nothing of this magnitude has been done in this country since Reconstruction following the Civil War, when an abortive effort was made to enforce the Thirteenth, Fourteenth, and Fifteenth Amendments to our constitution, which were designed to abolish slavery for the benefit of all of our people.

A major reason for my optimism about the future of affirmative action in higher education comes from the report in the *Journal of Blacks in Higher Education* ("Progress of Black Student Matriculations" 1999), which shows that the major universities in the South are firmly behind these programs. Among the nation's twenty-seven highest-ranked universities and twenty-nine highest-ranked liberal arts colleges, the University of North Carolina at Chapel Hill for the second year in a row had the highest percentage of Black freshmen in the entering class (412, or 12.1 percent), the same as in the previous year. This is more than triple the rate at Notre Dame, Berkeley, Carnegie Mellon, and the University of Chicago. In fact "the four top-tier schools with the highest percentage of Black freshmen are all in the South" The University of Virginia, Duke University, and Emory University all had more than 9.0 percent. The University of Virginia (which was built by slave craftsmen, but which admitted its first Black student only in 1959), was in second place at 10 percent, down from 11.1 percent the previous year. Virginia had been in first place for five years from 1993 to 1997. The premier universities in the South are now enrolling the most talented Blacks, who earlier had been forced to enroll in the segregated state-funded universities in their states. Quite clearly the South has now joined all other major university centers in our land in providing first-class education to all citizens. In 1997 the 105 historically Black colleges and universities enrolled only 16 percent of all Black college students (*New York Public Library* 1999, 176). In 1970 they enrolled 58 percent (Willie and Edmonds 1978, 92), and in that same year the overwhelming majority of Black college graduates had gone to those schools. Christopher Lucas (1994) in his *American Higher Education: A History* comments on this significant desegregation of American higher education for Blacks: "By 1987, for the first time in American history, black students were more likely to matriculate at predominantly White institutions than at traditionally black schools. Slightly less than one in every five black students was then enrolled at a black college" (247). He goes on to state that advocates of Black institutions are not agreed that this is all favorable, pointing out that 40 percent of the Blacks are enrolled in two-year institutions and might be better served by going to a Black college, 90 percent of which are four-year schools. They claim also that Black schools probably have a better success rate in graduating high-risk students, and in providing a generally more comfortable social life.

My own view is that students should choose the college or university they prefer but that great weight should be given to the advantages of receiving an education in an environment where everyone does not look,

behave, and think as you do. Particularly this is true as we become increasingly members of a world community. It is a positive gain for our nation that as we advance into the twenty-first century our Black and White middle-class leadership will have been educated in the same colleges and universities, giving them a foundational experience as they create “one nation indivisible with liberty and justice for all.”

Affirmative action to eliminate racial disparities in the health status of Blacks will require a fundamental change in our frame of reference, including a commitment to improve the health of all of our citizens who live in poverty. Even the health status of more affluent Americans does not compare favorably with other developed nations.