EPILOGUE

In the more than fifty years since my graduation from the University of Michigan Medical School in 1946, as the only African American among the 145 graduates, I have been both an eyewitness to and an active player in the changing role of Blacks in American medicine.

When I graduated, I was advised that I could choose my internship and subsequent postgraduate appointments from among no more than half a dozen hospitals. Half of them had almost all Black patients, and the others were general public charity hospitals serving low-income populations. It was only a few years later that increasing fractions of medical school graduates began to pursue additional years of residency training to become specialists. The medical world in those years was segregated by race and income, though this system was beginning to change with the end of World War II.

In 1946 the huge Wayne County General Hospital accepted me and another graduate from Meharry Medical College as its first Black interns. At the end of that year, during which we were well received both by patients and the hospital staff, we were stunned to find that we had not been invited to attend the staff Christmas party. One of the other interns, a White physician who had graduated from a southern medical school, told me that he and several others had argued that we should be invited. Having lost that argument on a vote, he wanted to make a gift to me if I would accept it. His father, the owner of a clothing store, had sent him two suits; he and I wore the same size, and he wanted to give one of the suits to me. I accepted, assuring him that he was not indebted to me because of the party. This incident taught me a personal lesson: young professionals, beginning a year as Blacks and Whites, could at the end of that year recognize each other as persons—as persons who see and renounce the intimate cruelty of race prejudice.

Another powerful experience occurred in the 1950s, when I was developing a private practice toward the end of my training. My first office was in our home in Brooklyn, an attractive brownstone that had been the

home and office of a White psychiatrist who was moving out of the neighborhood because it was rapidly becoming all Black. One of my White instructors, who supervised my psychotherapy cases, thought highly of my work and referred a young White schoolteacher to me. She had been sent to him by an internist who thought her psychosomatic problems might respond to therapy. She came to see me several times but then terminated. The internist, it turned out, had learned that the patient was being treated by a Black psychiatrist in a Black neighborhood, and denounced my instructor for sending the patient to me.

My instructor and I reviewed the situation in great detail and came to one important conclusion—I should relocate my office to downtown Brooklyn Heights, where most of the specialists practiced. Both Black and White patients would be comfortable on visits to me at such a site. Being accepted into one of those office buildings was a tortured process, but the fifth landlord or business manager I approached rented me an attractive office. By happenstance his firm managed the real estate properties of one of Brooklyn's largest Black churches.

As the next few years unfolded, my practice flourished. My patients were about evenly divided between Blacks and Whites, and I received referrals from my professional associates and personal friends, who were also about evenly divided between the two races. A number of my patients were family members of my White colleagues, who referred them to me for care. Contrast this with another story. A friend of mine, a White specialist in internal medicine, had for some years taken care of a prominent Black businessman who was plunged into a deep depression after his son committed suicide. The internist wanted to refer him to me, but the patient refused. He insisted on being referred to a White psychiatrist. My reaction to this is—you win some and you lose some. For the best treatment result, the patient must make the choice. But many of the Black middle class must overcome their view that Black specialists are second-rate. There is room for new learning all around.

My first year at Cornell, 1968, was in many ways a pivotal one. I had been selected by a search committee that consisted of two senior faculty members, who were convinced that Cornell should join other leading schools in developing an affirmative action admissions program, and three White medical students, who were quite generally activist in favor of affirmative action and against the Vietnam War. My career interests and activities convinced them that I was a good choice. Since, however, there was only one Black faculty member on the full-time salaried faculty, and her interests were primarily in research, and only two Black students from

Africa, I did not have much of a support system. Once a week a faculty member and I were joined by two other Black internists on the Cornell Voluntary Faculty who also had admitting privileges at the New York Hospital. Our meetings were an important source of friendly emotional support and general information.

The summer research program I designed required twenty very able minority students to be with us at the medical center for ten weeks following their junior year of college. Each student would work half time on the research project of a faculty member; in the other half of their time we provided them background information on the health care delivery system as it related to the health problems of minority communities. As the first year developed, I was given my own background briefing on potential friends within the medical school community. For the entire year I had lunch once a week with the three medical students who had been on the search committee. The two faculty members who had been on the search committee met with me almost as often. The selection of faculty sponsors was no problem, and my formal and informal support system rapidly expanded. It is of some interest to me that one of the three students from that original search committee went on to become a psychiatrist and is now chairman of the psychiatry department in one of the nation's leading medical schools.

During my eleven years at Cornell I felt great pride in helping produce the first large cohort of minority medical school graduates, who would become a part of the mainstream of medicine in this country. By 1980, when I left the school, I was convinced that only a long-term study of the career development of a large sample of minority graduates, compared with an equal number of their nonminority classmates, would establish how much difference they were making in the racial integration of American medicine. No longer were 85 percent of Black physicians coming from Howard and Meharry; now 85 percent were graduating from all the other U.S. medical schools. Thirty years later, with that study having been undertaken, we can see how much of a difference these physicians are making in the lives of many people.

Heading the psychiatry department at Harlem Hospital Center in 1982 was a decision I reached on feeling a need to be more fully involved in the changing field of psychiatry. Harlem Hospital at the time was a thirteen-hundred-bed general hospital with the full spectrum of medical and surgical specialties, located in central Harlem's population of 250,000, more than 90 percent Black. For five years the psychiatry search committee had been unable to select a candidate acceptable to Columbia University,

which held the affiliate contract to hire and supervise all physician staff, to the city's Health and Hospitals Corporation, which hired all other staff and financed the Columbia affiliation contract, and to members of the Harlem community. As a municipal hospital, Harlem Hospital Center always depended on support from the mayor, Harlem's political leaders and general community, and labor unions. The psychiatry residency training program had progressively weakened. My decision to accept the challenge to go to Harlem came from a belief that out of my experiences, background, training, and friendships within the medical establishment, I could develop a strong set of mental health services for the central Harlem community. Shortly after my appointment the psychiatry department grew from thirty-two to sixty-eight inpatient beds, with a large ambulatory service for all age groups. It accepted responsibility for staffing and running the drug treatment programs previously supervised by an ambulatory treatment service.

In time Harlem provided me with greater understanding of how the medical system works. On my retirement at the end of 1999 the hospital had shrunk down to 230 beds. With downsizing of patient care, all residency training programs became smaller; the psychiatry program, which had had thirty-five slots, was cut in half. A lack of political and community support, and the advent of managed care, threatened the hospital's survival. I learned that even though Harlem Hospital Center was on the surface a Black hospital, in reality it was not significantly controlled by Blacks. City and university politics, even more than labor union politics, made it impossible for the hospital leadership and community to carry out a relevant medical mission with sustained financial support.

As patients leave the municipal hospital system, seeking care in the private voluntary sector, it is quite possible that this shrinking of Harlem Center Hospital is for the best. As minority physicians leave the municipal hospital system, greater numbers move onto the staff of major university teaching hospitals. During my nearly twenty years at Harlem our large psychiatry residency training program only trained about four Black graduates from U.S. medical schools. While more than half of the five hundred we trained were Black physicians, they came from the Caribbean or from Africa. Most of the other trainees were from Third World countries. Medical and surgical residency training programs at Harlem experienced the same trend. In the 1970s large numbers of U.S. medical school minority graduates selected Harlem Hospital Center for postgraduate training, but this was no longer the case in the 1980s and 1990s. Where are they now going for training? To the major teaching hospitals around the nation.

As we have seen in the thirty-year progress report on affirmative action at Cornell, the medical school's minority graduates uniformly are placed in prestigious training programs. At Cornell there are currently forty-three fully salaried minority faculty, compared with one in 1970. This is an indication that affirmative action works, and that Blacks and other minority physicians are becoming securely included in American medicine.