

INTRODUCTION

This book is about affirmative action in undergraduate and postgraduate medical education, a significant part of my life's work. Affirmative action in medicine is defined comprehensively, covering not only the equitable opportunity to be admitted to the best medical schools and postgraduate training programs, but also the equitable provision of health care. Major emphasis is placed here on the serious differentials in health status between Blacks (or Afro-Americans) and Whites or (Euro-Americans), because the social, political, and economic contrast between these two groups has been one of the defining issues of our national history. As a Black physician and medical educator, I maintain that the persistence of a system of color caste consigns our people to a subordinate social role that is a handicap separate from the poverty Black people also endure.

More equitable recruitment of competent Black physicians can help meet the needs of Blacks who currently receive poor care. In 1970 the Association of American Medical Colleges (AAMC) and the medical establishment of our nation supported an affirmative action goal of admitting 12 percent minority students to our nation's medical schools by 1975. This effort fell short, achieving only 10 percent by that date. Again in 1990, the AAMC announced the aim of enrolling three thousand underrepresented minority students by the year 2000, but that effort failed by almost one thousand students. The reasons are clear. Medical schools quite properly will admit only those who are almost certain to graduate, and the substandard educational opportunity available to Black youngsters constricts the pipeline. Blacks become physicians at about one-half the rate of other ethnic groups (Petersdorf et al. 1990; Johnson 1998).

My outlook for future amelioration of this disparity is more optimistic than might be supposed, perhaps because of my personal life history. Both of my parents were born in the 1890s in a small farming village in Georgia. Following his military service in World War I, my father moved to Michigan in 1921 in response to labor recruiters seeking workers for the booming automobile industry. I was nine months old when, in 1922, my

mother and I joined him in Albion, Michigan. Fortunately Albion, then a town of about ten thousand, was both a small factory town and the home of Albion College, one of the best small schools in the Midwest. Fortunately, opportunities came my way. I grew up in a strong, albeit racially segregated, Black community where the men all worked and supported their families. I had the further advantage of excellent schooling, which led to Albion College and then to the University of Michigan Medical School, from which I graduated in 1946. My career has been in academic medicine, the last position being that of director of psychiatry at Harlem Hospital Center and clinical professor of psychiatry at the Columbia University College of Physicians and Surgeons in New York City, from which I retired after eighteen years at the end of 1999. My story demonstrates what one can achieve in this country, given the right combination of ability, a strong support system, and just plain luck. In other words, I have had the good fortune of living and struggling with the troublesome problems that are detailed in this book.

The state of health for Black Americans is a national problem; the overall mortality rate for Blacks is 1.6 times the rate for Whites. In 1996 Blacks had the highest death rates of any ethnic group for seven of the ten leading causes of death: heart disease, stroke, diabetes, lung cancer, colorectal cancer, breast cancer, pneumonia, and influenza (*Morbidity and Mortality Weekly Review* 2000; Williams 1998). In 1990 the age-adjusted death rate was higher among Blacks than Whites for thirteen of the fifteen leading causes of death. It was much higher (6.7 times) for homicide, 3.1 times higher for HIV/AIDS, 3.1 times higher for perinatal conditions, 3 times higher for kidney diseases, 2.7 times higher for septicemia, and 2.4 times higher for diabetes. Hispanic Americans and Native Americans also suffered high mortality rates, while Asian Americans had favorable indices.

This is a problem of national significance that will become more and more pressing in the coming decades. While ethnic minorities represented 18 percent of the population in 1970, by 1998 they represented 27 percent, and it is expected that by 2050 their proportion will have increased to nearly 50 percent of all persons in the United States. From 1980 to 1990, African Americans, representing 13 percent of U.S. population, increased from 30 million to 33.5 million. An increase of 1.4 percent per year, this is twice the growth rate of Whites. The Black population figure for 1990 is expected to double to 62 million by the year 2030; 84 percent of this will have been a result of natural increase, the remaining 16 percent from immigration. These demographic changes should influence current national health, education, and welfare policies, in self-defense as well as in consideration of

fairness, equity, and a concern for national unity (Shinagawa and Lang 1998). Unless significant policy changes occur in health, welfare, and human services, the general quality of life for all Americans will have deteriorated dramatically by the middle of this century. I believe we have the national talent and resources to meet this challenge, but it will require firm planning and sustained efforts: solutions will not automatically be produced by the economic market. Failure to plan and act could seriously jeopardize our world leadership role.

The U.S. Department of Health and Human Services (HHS) has tried to develop initiatives to improve the health status of minority populations. In 1979 these disparities drew attention with the publication of *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. The then secretary Margaret Hackler established the Office of Minority Health in 1984 to set goals to reduce these disparities. This was followed by Healthy People 2000 and most recently by Healthy People 2010, which was the third statement of ten-year health objectives for all Americans and which in its last formulation aimed at eliminating, not merely reducing racial and ethnic disparities by 2010. In fiscal year 2002, HHS projected expenditure of 5.7 billion of its 468.8 billion budget on minority health programs, including 158 million for the newly created National Institutes of Health (NIH) National Center on Minority Health and Health Disparities, established in November 2000, which absorbed and elevated the mission and goals of the Office of Research on Minority Health, in existence since 1990. (See HHS 2001.)

On October 26, 1998, the most complete progress review thus far was made of Healthy People 2000 objectives for Black Americans (HHS 1998), revealing progress made from 1987 through 1996. The then surgeon general David Satcher and staff made the presentation to a panel of governmental and nongovernmental experts in the field. Reported health status changes were both favorable and unfavorable. For example life expectancy for Black men increased in 1996 for the third consecutive year to a record 66.1 years, seven years less than for other men; Black women born in 1996 could expect to live to age 74, five years less than for other women.

Age-adjusted death rates met the targets set by the Healthy People 2000 projection in the following conditions: all cancers, hepatitis B, lung cancer, and unintentional injury. However, these reductions will not approach parity with the general population. The most encouraging report was that the number of Black women who had breast exams and mammograms will reach parity. Similar good news was seen in reduced percentage of low birth weight babies and in infant mortality, but there was no change in

percentage of very low birth weight babies, and none of these infant-related conditions will meet general population parity. Similarly, while the homicide rate for Black men slowly declined in the 1990s, the rate will continue to be several times greater than for all other men. Coronary heart disease deaths steadily declined during the last decade, and the Healthy People 2000 target will be met. Several other indicators were improving but not fast enough to reach target: breast cancer deaths, tuberculosis, early prenatal care, hospitalization for pelvic inflammatory disease, primary and secondary syphilis, pneumococcal and influenza vaccinations. Several other indicators were dramatically worse: HIV/AIDS; asthma hospitalizations and deaths; diabetes-related deaths; maternal mortality, which is five times greater than for White women; end-stage renal disease; and lower extremity amputation. In all candor, it does not appear that significant overall reductions in health disparities are occurring.

An important next question is, are these health disparities due to disparities in health care delivered to Black Americans? In March 2002 the prestigious Institute of Medicine announced their 562-page report, in which the institute reviewed more than one hundred of the best studies and concluded that ethnic minorities who have the same income, insurance coverage, and medical conditions as Whites receive decidedly poorer care. Among the five major findings were their first: "Finding 1-1: Racial and ethnic disparities in health care exist and, because they are associated with worse outcomes in many cases, are unacceptable" and their second (Finding 2-1), "Racial and ethnic disparities in health care occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life" (Smedley, Stith, and Nelson 2002, 17).

Among their recommendations, the foremost and general one relates to increasing the awareness of these disparities among the general public and key stakeholders, especially physicians and providers of care, and to "increas[ing] the proportion of underrepresented U.S. racial and ethnic minorities among health professionals" (Smedley, Stith, and Nelson 2002, 18). In response to a growing awareness of the need for fundamental change in the American health care system, an earlier report of the Institute of Medicine's committee on the quality of health care (Committee on Quality of Health Care in America 2001) listed six aims over the next ten years: to make the health care system more safe, effective, patient-centered, timely, efficient, and equitable. Equity was conceived as being addressed at the levels of both population group equity and the individual patient: "the quality of care should not differ because of such characteris-

tics as gender, race, age, ethnicity, income, education, disability, sexual orientation, or location of residence (Committee on Quality of Health Care in America 2001, 5–6, 53). Important documentation of these current needs was presented by the Commonwealth Fund's national survey, which showed that 30 percent of African Americans notably by age fifty but across all age groups are living with higher rates of chronic illness but are more likely to have been uninsured in the past year, compared with 46 percent of Hispanics, 20 percent of Whites, and 21 percent of Asians. Blacks also are less likely than Whites to have a regular doctor (the survey indicated that 28 percent of Blacks, as compared with 19 percent of Whites, do not have a regular doctor), and a greater percentage of Blacks (23 percent) than Whites (16 percent) report problems communicating with their doctor. Equal percentages of Blacks and Whites (16 percent in each case) feel that their doctor has treated them with disrespect (Collins, Tenny, and Hughes 2002).

Further corroboration of specific problems of physicians relating to Black patients was found in the large 2001 national survey of 2,608 physicians and of 3,884 members of the general public (Kaiser Family Foundation 2002). Only a minority of physicians believe that the health care system very often treats people unfairly based on the patients' monetary resources, (47 percent), fluency in English (43 percent), educational status (39 percent), racial or ethnic background (29 percent), sexual orientation (23 percent), having a disability (23 percent), or gender (15 percent). However, when responses were tabulated on the basis of the racial or ethnic background of the physician great differences of perception were revealed. To the question, do you perceive that members of minority groups receive unfair treatment "rarely or never" the following percentages of physicians responded affirmatively: White (75 percent), Asian (65 percent), Latino (47 percent), African American (22 percent). Similar questions about discrimination occurring "rarely or never" on the basis of other variables received similar percentages of affirmative responses: educational status—White (62 percent), Asian (64 percent), Latino (49 percent), African American (27 percent); fluency in English—White (57 percent), Asian (55 percent), Latino (37 percent), African American (26 percent); monetary resources—White (57 percent), Asian (55 percent), Latino (37 percent), African American (26 percent). Female physicians were also more likely than male physicians to say there was unfair treatment based on race or ethnicity of the patient: female (33 percent), male (10 percent). Female physicians also perceived more unfairness based on the patient's English fluency—a 24 percent difference; on whether the patient is male or

female—a 23 percent difference; and because the patient was disabled—an 18 percent point difference. Even the general population is more likely than physicians to see unfairness based on the patient's monetary resources—a 24 percent gap; ethnic background—an 18 percent gap; disability—a 17 percent gap; English fluency—a 15 percent gap; sexual orientation—a 13 percent gap; gender—a 12 percent gap; and education—a 9 percent gap. With these findings alone we can see how far apart we can be even as to the perception of a problem requiring solution. But we can see also how fortunate it is for the American people that the profession of medicine is becoming more inclusive of persons from diverse backgrounds. Physicians, like other people, tend to see what they look for, including problems and solutions, all of which means that we need many sets of eyes and ears and minds working toward building a better health care system.

There can be no denial that we are in the process of reinventing the American health care system. In the 1980s, a new set of challenges arose. Conventional fee-for-service medicine was failing to contain the runaway escalation of health care costs. Neither doctors nor patients nor hospitals could control their demands for increasingly costly new forms of care deriving from new technological discoveries. Since third-party payers, insurance companies, and the government paid the bills, there was no immediate restraint on medical providers. Both Republican and Democratic administrations failed to contain these costs. Managed care organizations (MCOs) arose on the scene, competing with each other to provide all medical care to a defined group of enrolled persons, promising to hold down costs by controlling physician and hospital decisions through requirements for prior approval. This increased commercialization of medical care has completely transformed the field (Fuchs 1998, 9–29; Ludmerer 1999, 349–70). Quite aside from the fact that 44 million people have no health care coverage and are therefore left out of the system, MCOs are tempted to provide the least possible amount of care and not to enroll high-risk populations who would reduce profit margins. Physicians are, in fact, in some cases rewarded in their paychecks for providing *less* treatment to patients. It comes as no surprise, then, that managed care increases the vulnerability of poorer and minority patients. Because poverty and ethnicity are closely intertwined and are known to be associated with adverse health outcomes, quality performance measures could be used to guide corrections of inadequate medical care.

Many of these problems can be solved by a resolute use of existing resources as well as new system changes (Fiscella et al. 2000). Fiscella et al.

propose five principles that could address these disparate outcomes under existing laws, rules, and regulations of accrediting and reimbursement agencies.

1. The problem must be addressed and services allocated by considering not just medical diagnosis but also the poverty or ethnicity of the patient.
2. A new mandate from the president, Health and Human Services, organized medicine and public health, and general public leadership should include requests for new funds to allow the collection of class-based and ethnic-based information by managed care organizations as well as other providers who would not otherwise develop a new and uniform data collection procedure.
3. Existing quality performance measures should explicitly address poverty and ethnic group membership.
4. Population and regional benchmarks for standards of performance should monitor whether vulnerable groups are being enrolled or disenrolled, as well as being provided with adequate care as determined by preestablished standards.
5. Reimbursement rates should be adjusted to compensate plans for the quality of care provided to these vulnerable groups, and to disaccredit providers who are unwilling to be held accountable (Fiscella et al. 2000, 2581).

These measures would, of course, require political leadership, and taking into account concerns for privacy could firmly link the national objective of eliminating racial/ethnic health disparity to continuing quality improvement methodology (Fiscella et al. 2000, 2581–82). (Some patients might object to identifying themselves by race or ethnicity, and some hospitals might resist receiving a report card showing their treatment outcomes along ethnic and income class lines. Fiscella et al. state “Public input to discussions regarding the tension between the right to privacy and equity in health care are essential” [2582].) David Barton Smith (1999, 312–36) summarizes indicators by means of which communities, health plans, and health care organizations could be monitored on their achievements in reducing racial health disparities.

In 1900 life expectancy at birth was forty-eight years for Whites and thirty-three years for Blacks. Over the next century the quality of life for both groups improved dramatically, so that by 1990 life expectancy was seventy-six years for Whites and sixty-nine years for Blacks. Moreover, the gap between the two groups was reduced from 14.6 to 7.0 years. Yet Blacks are in the position now that Whites were forty years earlier. Throughout the last century Black family income has remained in the range of 50 to

60 percent that of Whites, while the disparity in family wealth is even more severe. The net household wealth for Whites is ten times greater than that of Blacks: among families in the lowest quintile of income the median net worth of Black households is *one dollar*. (The comparable figure for Whites is over ten thousand dollars.) Differential in home ownership is the primary reason for this difference.

Blacks pay a hidden tax because of color, as was demonstrated in a 1990 study of gender and racial/ethnic discrimination in purchase price of new cars. Black and White male and female test buyers found these dramatic differences: White men were offered the best price, White women paid a 40 percent markup, Black men a 200 percent markup, and Black women a massive 300 percent markup. Likewise, most goods and services are priced higher in the Black inner city than in the more affluent suburbs (Ayres 1991).

During the 1990–91 economic downturn Black Americans had a net job loss of 59,500 jobs, while Whites gained 71,000, Asians 55,100, and Latinos 60,000 (Williams 1998, 309). Last hired and first fired is still the signature of the color caste system. Unemployed men cannot marry and provide for their children or inspire them to go to college. Chronically high unemployment rates are an example of institutionalized racism, but a man who loses his job during a recession cannot successfully bring a lawsuit against his employer. Seniority rights automatically strike down those who are last hired. These social realities have relevance to the fact that in 1980 Blacks sustained 59,000 preventable deaths, roughly twice as many as Whites (William 1998). Matters worsened by 1991, when Blacks suffered 66,000 preventable deaths (302). If these matters were more widely known, and this knowledge wisely used to guide the nation's health and socioeconomic policy, we would create a stronger, healthier, and higher quality of life for all Americans. In the broadest context this would be affirmative action in medicine.

The book is organized into three parts. Part I discusses the purpose and history of affirmative action in U.S. medical schools and the history of civil rights in health care, and provides a case study of Cornell University medical college. Part II presents data on approximately 2,000 minority and nonminority medical students throughout the country who graduated during the five year period from 1973 to 1977, analyzing the hospitals they selected for post graduate training, the geographic and specialty distribution of these programs and affirmative action in graduate medical education. In part III this cohort was followed up 30 years later, utilizing

data showing their practice location and specialty distribution in 1994 and 1995. A final chapter draws from the previous chapters, and my own experiences, to offer my opinions on the future of affirmative action in medical education.