Bakke-ing Up the Wrong Tree: NEW MYTHS FOR OLD RACISM AND SEXISM: The second in a two part study of medical school admissions in the post-Bakke era.

The cumulative effects of inflation, changes in federal financial support and the institutionalized racism have hurt affirmative action programs in health professional schools and reduced the percentage of minority students entering these schools to that of ten years ago. In their wake, rationalizations have developed to make this failure palatable to majority and, to some extent, to minority groups.

Besides the attributions laid to the "chilling" impact of the Bakke and DeFunis legal decisions, which locate the responsibility for their failure beyond the control of the academic health establishment, there are numerous myths, usually based on some modicum of fact or unexplained stereo-
types, that quite simply blame the victims of discrimination for their plight and hold them entirely responsible for changing their situation. These myths serve an ideological function, narrowing the terms of the debate and the field of alternatives. These myths are insidious, so that they have been adopted at times even by proponents of affirmative action, such as the Student National Medical Association, the editorial writers of the New England Journal of Medicine, and the guardian of liberal academic interests, the American Association of Medical Colleges (AAMC).

The danger of such ideology is that it legitimizes the dominant interests which are served by a system which dismisses affirmative action as only serving the interests of those individuals who directly benefit from it. The success of the ideology—and the system it supports—is to make the possibility of alternatives unthinkable, curious heresies, or irrelevant eccentricities (1). It results, too, in a patchwork of narrow solutions, aimed at mythical problems, that quite predictably fail to accomplish their goals, yet relieve the participating institutions of their public obligations, atone for liberal guilt, and leave untouched and unquestioned the structural inequities which have created and perpetuated racial and sexual discrimination in the health professions since Flexner.

"Blacks and other minorities have lower aspirations and less motivation."

The old racist stereotype of the lazy, shiftless Black has been reincarnated, in psychological jargon, as rationalization for the limited progress made in the drive for minority parity. In an article published in the prestigious New England Journal of Medicine, nominal advocates of affirmative action cited the low degree expectations of Blacks as a hurdle to parity in medical schools (2). This is supported by the observation that the combined percentage of Black students aspiring to become physicians, osteopaths, dentists and veterinarians is less than for whites. Yet in every year examined, the study referred to found a greater percentage of Black freshmen aspiring to the M.D. or D.D.S. degrees than white freshmen (3). In fact, Blacks have higher degree aspirations than non-Blacks in all other advanced degrees identified—Masters, Ph.D., Ed.D., L.L.D., and J.D. (4). These higher aspirations persist well beyond the freshman year of college.

For medical students surveyed in 1974-75 the mean number of years of residency anticipated was directly proportional to the student's socioeconomic background—the greater the family income, the greater the number of years of residency anticipated—except for Black medical students who planned upon more years of training than any other racial or ethnic group (5). On self-ratings of students aspiring to health careers of all types, Blacks and Native Americans ranked highest in their drive to achieve, greater than whites, Asian- and Hispanic-Americans (6). In the same study Black and Hispanic students evinced greater concern with achievement in their chosen fields than non-minorities. These high expectations were also matched by realistic assessments of the relative financial and academic disadvantage of minority students (6).

When the best Black high school graduates cited financial concerns and fears of racism and sexism as reasons for not pursuing professional educations, the AAMC Education News blindly observed, "Considering that these were the best students, this again illustrates the very limited educational aspirations of the rural Black high school senior" (7). Lower aspirations and motivation are an old fiction, revived for a new racism.

"Blacks have greater academic attrition from colleges and from careers in the health fields."

In the article mentioned above, a deeply ingrained belief was passed as fact: the authors claimed that Blacks drop out of college and from health career majors at a greater rate than non-Blacks (2). If junior college students are excluded, this is simply not true. The author of the source cited to support their argument, in fact, found that when considering only four year colleges and universities, "Black students at such institutions were, in actuality, somewhat less likely to drop out than were non-Blacks whose abilities and past achievement were comparable" (8). The form and amount of financial support plays an important role in all students' success in completing college (9; see also initial article in this series).

In fact, Black freshmen choosing health fields (not just pre-medical) were more likely to remain in these fields but less likely to be recruited to them from another field after graduation than non-Blacks (10). A greater percentage of Blacks and Native Americans received baccalaureate degrees in the health professions than non-minorities (11). Were the health sector not such a caste system, if it allowed some vertical mobility between levels without expensive and full-time retraining and with credit for experience, considerably more minority men and women might rise to the top the hard way.
A DIRECT HIT ON THE BOTTOM LINE

Corporations are intensifying their attack on rising health care costs, applying an unconventional amount of power in pursuit of conventional goals. Businesses are encouraging utilization review, hospital bed reduction, outpatient and surgi-center treatment, second and even third opinions on surgery, preadmission testing, preauthorized hospitalization, and in some cases that old faithful of cost cutting strategies, cost-sharing by employees.

While such initiatives are not new, the current series of attacks are more militant than previous efforts because zooming medical care costs have hit corporations in their most sensitive spot—the bottom lines. In 1978, companies paid for about $40 billion of the nation’s $180 billion health care expenses. And medical benefits now account for as much as 10 percent of total compensation paid by some firms.

Observers are predicting that the corporate initiatives will produce significant changes in the medical care system, bringing it even further into the fold of capitalist institutions. The high costs give corporations one of the two basic ingredients of institutional change in America—incentive. And they already have the other ingredient—power. This new corporate thrust “lets the medical-care industry know that people in real power centers are searching for ways to make the system more efficient,” says Terence E. Carroll, executive director of the Comprehensive Health Planning Council of Southeastern Michigan.

Corporations have been working with insurance carriers to try to cut their medical care expenses for several years, but they are now trying to increase their clout by joining together in regional groups. (So much for cutthroat competition, at least where a common enemy to profits is found.) Inspired by a U.S. Chamber of Commerce campaign and participation by some executives in the Washington Business Group on Health, an offshoot of the powerful Business Roundtable, corporations have formed more than a dozen regional groups in the last year or two, like the Fairfield/Westchester Business Group on Health in the suburbs north of New York City and the Employers Health Cost Committee of San Diego.

Some corporations are forcing workers to pay more of their own health care costs through what is misleadingly known as cost 'sharing.' The employees of Metropolitan Life Insurance Co. were recently shoved a step backwards and began contributing to their own benefit plan, for the first time in years.

Unions tend to fight such big business strategies tenaciously. In fact, cost-sharing was the issue that stalled the 1976 auto labor negotiations. But the United Auto Workers, for one, realize that money needlessly going to finance an inefficient medical system could be going to their members as higher wages. The UAW has joined with the Big Three auto makers to fight excessive health care costs. The coalition recently got legislation through the Michigan law makers that will phase out 10 percent of Michigan’s hospital beds over five years.
years, saving 4 percent of the state's $3 billion annual hospital bill.

The unanswered question about this battle between corporate capital and the medical establishment (including medical capital) is how the contradiction will work itself out. Most observers are speculating that business will push hard, but not far. If it threatened to push the medical care system too far toward increased health advocacy—to the point where medicine becomes truly preventive and begins to struggle with the sources of ill health—corporations would no doubt pull back, since many of the sources of illness are found in the normal business activities of these same corporations. The challenge for progressive health activists would seem to be how to use the contradictions arising from the newly-used clout of business to begin a process of reform.

—George Lowrey

Source: Business Week, August 6, 1979.

EMPIRES MARCHING ON

"Consolidation" is the word these days to deal with "overbedding" and fiscal survival. On the Upper West Side, Roosevelt and St. Luke's Hospitals recently announced plans to join forces, prompted by state planners and the New York City HSA.

Fast on the heels of the Roosevelt – St. Luke's announcement, plans were announced to consolidate New York Infirmary and Beekman Downtown Hospital in the Wall Street area. The planned consolidation includes closing the New York Infirmary facility (which is next to Beth Israel) and expanding at Beekman Downtown.

Because of a larger capacity and expanded services, the consolidated facility will receive a Medicaid reimbursement rate increase of from $27 to $63 a day. The HSA praised the plan as increasing accessibility and eliminating duplication of services in the area.

Passing mention was made that New York University Medical Center would get the teaching affiliation over the expanded facility. Since the fiscal crunch and aggressive state action has put the squeeze on smaller hospitals, the medical empires have been the only winners. Their turf has been expanding as they fill the vacuums left by closing hospitals, and are taking survivors under their protection.

Three years ago, cash rich NYU bought outright the small Midtown Hospital for the sole purpose of closing it. In a quid pro quo with state planners obsessed with overbedding, NYU then received permission to build its Cooperative Care Center next to University Hospital. (The Cooperative Care Center is a new concept in patient care. Services and staff are kept at previously unheard of low levels, and supposedly not-so-sick patients and their families take primary responsibility for patient care. The idea is supposed to save money, and no doubt does for NYU, but the rate is virtually the same as that charged for the high tech-
memoriam

Almost twenty years ago, February 1, 1960, to be exact, four students from North Carolina Agricultural and Technical College sat down for lunch at the counter in Woolworth’s in Greensboro, North Carolina. Five days later they and the others who had joined them had still not been served—because they were Black. On the sixth day Woolworth’s announced that they were closing temporarily. This dramatic step taken by the nascent civil rights movement created the “sit-in” and spawned a generation of militant Black and white students and activists.

On November 3, 1979, Greensboro again became the setting for another chapter in the long, unending struggle for civil rights. Five demonstrators protesting the resurgence of the Ku Klux Klan were killed and 10 others were wounded when members of the Klan opened fire on the demonstrators from a yellow van armed with a small arsenal of weapons. Five anti-Klan demonstrators were killed—Cesar Cauce, Michael Nathan, Bill Sampson, James Waller and Sandra Smith. A sixth demonstrator, Paul Bermanzohn, suffered head wounds and is now paralyzed on his left side.

The cold-bloodedness of these murders shocked even those hardened by the Klan’s history of racist outrages against innocent people and human decency. The loss was even more painful and personal for those of us at Health/PAC when we learned the identities of those who were murdered. James Waller was a member of the Lincoln Hospital Collective in the early 1970s. Paul Bermanzohn had been a contributor to the Bulletin in 1974 when he co-authored a story on the Duke University medical empire.

We mourn their deaths and grieve with their families, friends, and all those who share the principles for which they stood and died, so much an anathema to the Klan that they became targets for assassination.

An appropriate elegy for the Greensboro deaths, especially for the pediatrician who served in that radical experiment in community-worker control of a hospital in the South Bronx, was posed in a question by another member and an organizer of the Collective. Fitzhugh Mullan asked in his autobiography, White Coat, Clenched Fist, “Did we remain faithful to the radical precepts that brought us to Lincoln after we left or did we burn out, drop out, or slip back into the mainstream? . . .?” The answer for James Waller is quite simply . . ., yes, he remained faithful to radical precepts.

To the legion of nameless victims of the Klan’s violence, a symptomatic outgrowth of the racist and reactionary economic system in which we live, we must add five more who have fallen in our streets in the name of justice. We wish to take this moment of sadness to extend our sympathies and condolences to their families and friends and to re-dedicate ourselves in their names to the causes of racial and economic justice and human rights at home for all.

A defense fund has been established to defend those demonstrators arrested after the attack. Send contributions to: Greensboro Justice Fund, 39 Bowery, Box 404, New York, N.Y. 10002.
to be in five places at once.

Critics of this blame-shifting could themselves point to the direct relationship between the cutbacks and deaths. The incident at Metropolitan adds a slightly new twist to the cutbacks analysis, however—the effects of the threat of cutbacks.

Metropolitan has been suspended in limbo ever since the Mayor's announcement of his intention to close the hospital. Staff morale has plummetted; workers are opting to leave rather than be laid-off. Prospective workers are reluctant to come to Metropolitan for fear of losing their jobs in the near future.

Assurances by some City and HHC officials to the effect that Metropolitan will not be closed, or at least that the decision is negotiable, have merely added to the confusion. The net effect is that jobs go begging. The Medical staff is down to nearly half strength, for instance.

What the budget cutters have been unable to do directly because of community and health worker protest, they are accomplishing indirectly. By merely casting doubt on the future of an institution the budget cutters can obtain tremendous cost benefits.

As health workers stagger under an increasing workload and somehow manage to "cope," temporary vacancies have a way of being converted into a permanent arrangement. Every staff position that remains unfilled means money saved, a more impossible workload, further deterioration of services—and unnecessary deaths.

—Glenn Jenkins

Nassif, Janet Zhun

HANDBOOK OF HEALTH CAREERS
A Guide to Employment Opportunities
Foreword by John H. Walker III, Director of the National Health Careers Education and Information Project

As the country's second largest industry, the health field employs over five million people in more than 200 different occupations. Career opportunities are dramatically expanding, and most positions require only two to four years of training. In simple straightforward language, the Handbook explores major areas of employment, educational preparation, work responsibilities, financial aid programs, and practical advice on the job market for each health career. The author provides an extensive bibliography and a roster of over 100 health organizations that supply career information, financial aid or employment assistance. A chart outlining the U.S. Department of Labor's occupational outlook for the health field through 1985 is particularly useful.

Although the demand for qualified health care professionals is increasing, few persons are aware of the numerous career opportunities outside of traditional health occupations, such as the physician or nurse.

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In addition, between 1966 and 1974, interest in health careers among minorities increased 106 percent, almost twice the increase among white students. One-and-a-half times more Native Americans and twice as many Blacks and Asian-Americans showed interest in health careers during this time, so that the latter two groups were actually over-represented among health career aspirants (6). Most striking of all were the increases in minority students aspiring to nursing and medicine (200 percent and 136 percent, respectively) compared to whites (110 and 14 percent, respectively). Thus the growth in interest among minority students in medicine was almost ten times that of whites, in nursing almost twice that of whites! To prepare for these careers, among Blacks there was a 110 percent increase in premedical majors between 1966 and 1972, a 233 percent increase in therapy majors, a 218 percent increase in bio-physics, and a 168 percent increase in biology majors. The problem does not seem to be related to attrition or lack of sustained interest in health careers.

"Recruitment of minorities to medicine and the health professions should begin in high school and earlier."
The early decision by Black medical graduates to study medicine (12) and the relatively small percentage of Black and minority high school graduates who go on to college, compared to whites, has been used to divert attention on minority recruitment as far away from academic health institutions as possible (3). This recommendation was first made in the 1940's (13)! A New England Journal of Medicine editorial moved even further away, to Projects Head Start and Follow Through!

An effort to recruit and follow students from high school, conducted by the AMA itself, disproves this as a primary approach to affirmative action. The AMA's Project Talent surveyed 11,507 high school graduates and then followed their progress toward medical school. Those who chose medicine as a career in high school and were ultimately enrolled in medical school represented the highest socioeconomic group; the next highest socioeconomic group were those who chose medicine but failed admission. The middle group chose other fields in high school but were ultimately enrolled in medical school. The lowest socioeconomic group was those choosing medicine but never applying (14). This was confirmed again in 1974 when the best and the brightest Black high school graduates in rural Virginia were found not to seek professional educations because of financial, racial, and sexual barriers (7). In view of this pattern, generating more high school interest among the disadvantaged without lowering socioeconomic barriers would appear only to generate more failure and frustration. Later recruitment, therefore, appears more fruitful, given the relative lack of recruitment during college to the health professions among minorities. This may be particularly true of the less highly visible health professions—osteopathic medicine, optometry, dentistry, podiatry, and pharmacy. The vast majority of Black college graduates pursuing advanced degrees still choose education, five times the number choosing health professions. Once the only available field for Blacks, education offers the same mixture of cultural opportunity and coercion that nursing or pediatrics has offered to women. The comparable opportunities for service and security in the health professions might attract many capable candidates. Interestingly, primary care physicians are among the latest to choose medicine (15).

"The pool of college undergraduates and minority applicants is not large enough to achieve representative minority enrollment in the health professions."
The growth of the percentage of Blacks and minorities among college students has continued through this decade. A greater proportion of Blacks between 16 and 34 years now enter college than whites (11); a greater percentage of college-aged Blacks from the $5,000 to $15,000 income bracket entered as freshmen in 1977 than whites (16). Blacks represented 5.2 percent of university, 11 percent of four-year college, and 13.1 percent of junior college students; Hispanic students made up 2.7, 3.9, and 7.1 percent of these enrollments, respectively (11). Three times the number of
Blacks and twice the number of Hispanics attending universities are enrolled in four-year colleges. Many of these colleges are the traditionally Black colleges, which still award almost half of all Black baccalaureate degrees (11). About 80 percent of all Black physicians and virtually all Black dentists are graduates of these institutions. Black college graduates have earned almost 75 percent of all Black Ph.D.'s in the natural sciences, almost all acquired at white universities; even in the progressive 1960's a higher percentage of Black Ph.D.'s came from these institutions than during the previous decades (17). With this impressive record in the face of open and sanctioned discrimination, the potential of Black colleges when these barriers are supposedly lowered would seem to be unlimited. However, predominantly white medical schools have accepted a decreasing percentage of their applicants from the Black Colleges since 1970 (18). The professional schools presume that Black students from predominantly white institutions are better prepared for and adjusted to the white medical school environment (read: have learned their place) (18). Howard and Meharry do not participate in this institutional racism and enroll a higher percentage of their applicants from the Black colleges (18). With this degree of institutional racism evident, discounting a huge pool of potential candidates, it is not surprising that almost 18 percent of all Black applicants only apply to Howard and/or Meharry (18).

A summary of the fate of the Black applicant pool from 1970 to 1977 shows the expanding

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<td>966</td>
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<td>1977-78</td>
<td>2,482</td>
<td>30.6</td>
<td>959*</td>
<td>38.6</td>
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* actual new first year students

Sources:
pool of physician aspirants and increasing interest in medicine among Black college students, presented in Figure 1. The aspirant pool has more than doubled from 1969 to 1973 (the potential applicants for 1973 to 1977). Meanwhile, the portion of aspirants who actually do apply and the percentage who actually are accepted have declined, the fall in the applications realized beginning just one year after the dramatic drop in the acceptance rate in 1972-73.

The percent of women and minorities accepted directly affects the number who apply; at one school where 22 percent of those admitted were women from a pool of 12 percent, the following year had a 98 percent increase in female and 15 percent increase in male applicants (19). The number of Black applicants has stayed about the same since 1972-73, the year when the acceptance rate was lowest (Figure 1). While some see this as the consequence of the backlog of older applicants being dried up, by 1974 the median age of Black and white students accepted to medical schools was almost identical (23.6 and 23.3 years, respectively) (7). Most of the loss of applicants realized has occurred since then. The barriers to medicine are again returning. Increasing numbers of potential applicants are being discouraged and lost during their college years, so that the gains minorities have made in the undergraduate schools are being limited by the professional schools. The causes here are political and economic, not the depletion of a mythological "backlog of qualified candidates."

"To admit more minority students, health professional schools will have to lower their admission standards."

The heart of the controversy in the Bakke case was the separate processes employed at UC-Davis for regular and disadvantaged applicants. An AAMC study demonstrated that racial status had greater impact than economic status upon the traditional selection factors of grade-point averages (GPA) and medical college admissions tests (MCAT). The generally lower GPAs and MCAT scores for minority students and their high repetition rates of academic courses are cited as evidence that "unqualified" applicants are being admitted.

This argument neglects the long controversy surrounding the MCATs ability to predict any outcome of medical training except performance during the first year. Personality traits, particularly in combination with "academic" variables, have proven to be the most powerful predictors of not only medical school grades, but also scores on the National Board of Medical Examiners tests (21) and overall medical school performance (22). Most recently, moral reasoning has been shown a predictor of clinical performance (23). Much evidence has accumulated which shows that standardized test scores cannot be employed accurately to predict performances between Blacks and whites or applied in the same manner among groups of Black or white students (24). Work at the Cultural Study Center at the University of Maryland has shown that the constellation of positive self-concept, realistic self-appraisal, long range goals, leadership experience, community service, and preparation for racism to be a measurable and useful predictor of success for minority students (24). The GPAs and MCATs of minority students are currently at the same level as that of all admitted students in the early 1960's and their retention and progress in medical school is comparable to all students during those years (25). Minority students, frequently starting behind other students, have shown that they can and do catch up by the end of the medical education process (7). Many of these non-academic traits and those found to correlate best with superior performance in medical school are those which minority students aspiring to health careers identify more than majority students in self-descriptions (6, 75).

Several studies have also found that lower class students have had to have higher grades to gain entrance to medical school (27, 28). Acceptance rates to medical schools increase directly with family income, even though some of the middle income groups have the highest GPA's and MCAT's (29). The median family income of those accepted was $2,300 more than that of those who were not (29). No class action suit has ever been brought against applicants whose families earn more than $50,000 who are admitted at a higher rate than any other group, yet have lower GPAs and MCATs than many other income groups! This has been going on since Flexner, seventy years ago (30).

It is now well established that the likelihood of an individual pursuing a primary care practice is inversely related to family income, so that admissions policies which perpetuate class privilege are in direct contradiction with the health manpower goals of encouraging primary care practice espoused by the Congress and former HEW Secretary Califano.

Among all applicants 22 percent of those accepted but 31 percent of those rejected indicated interest in primary care, while 23 percent of those accepted and 19 percent of those rejected indicated interest in research (19).
The continuous MCAT and GPA inflation required of admissions also contradicts these national priorities, related as they are to family income (29). It also ignores the epidemic grade inflation at many prestigious institutions whose reputations rest in part on the ability of their students to compete successfully for admissions; at Harvard 85 percent of the 1977 graduates were given honors, compared to 39 percent in 1957 (31).

There is little question that minority students not only bear the burden of racial and cultural barriers to parity in the health professions, but disproportionately that of class (see Table 2). The controversy over admissions standards seems not to be one of maintaining quality but that of maintaining race and class.

"There has been a uniform and comprehensive effort to recruit and retain minority and women students and faculty in U.S. health professional schools. Everything that can be done is being done."

Minority and women students. Were there, indeed, a real shortage of qualified minority candidates for the health professional schools, competition among the schools would lead to a relatively even distribution of minority students among predominantly white institutions. Nothing could be further from the present situation. Certain institutions have demonstrated a sustained ability to attract and retain under-represented minorities and women; others have failed or never even tried. It should come as little surprise that most of these schools that have been successful recruiting and enrolling minorities are the same that have admitted significant percentages of women, including all the predominantly minority health institutions (i.e., Howard, Meharry, and Morehouse). No shortage of qualified women candidates has yet been identified. The New Jersey College of Medicine and Dentistry and Rutgers, UC-San Francisco and Irvine, Michigan and Michigan State, and New Mexico have consistently maintained and graduated the greatest percentage of minority professionals in medicine, dentistry, and pharmacy among the predominantly white schools. Three state systems—California, Michigan, and New Jersey—represent a disproportionate number of the health professional schools with higher minority enrollments, while both West Virginia medical schools have no minority students (32). These institutional policies cross over disciplinary lines, so autonomous schools of medicine, dentistry, and pharmacy at one institution may consistently have strong or weak affirmative actions efforts (see Table 3). These pervasive institutional attitudes are not

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Table 2

Percentage Distribution of U.S. Medical Students by Family Income, 1976-77

<table>
<thead>
<tr>
<th>Income Level</th>
<th>All U.S.*</th>
<th>Total</th>
<th>White</th>
<th>Black</th>
<th>Hispanic &amp; Native American</th>
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<td>Less than $5,000</td>
<td>13</td>
<td>5.0</td>
<td>2.9</td>
<td>22.3</td>
<td>15.6</td>
</tr>
<tr>
<td>$5,000 to $9,999</td>
<td>23</td>
<td>10.8</td>
<td>8.7</td>
<td>25.2</td>
<td>25.2</td>
</tr>
<tr>
<td>$10,000 to $14,999</td>
<td>24</td>
<td>21.8</td>
<td>21.3</td>
<td>23.5</td>
<td>27.4</td>
</tr>
<tr>
<td>$15,000 to $19,999</td>
<td>18</td>
<td>16.1</td>
<td>16.7</td>
<td>11.4</td>
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<td>$20,000 or more</td>
<td>22</td>
<td>46.2</td>
<td>50.3</td>
<td>17.6</td>
<td>20.6</td>
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</table>

*for 1974 (from U.S. Bureau of the Census)

Source:
limited to admissions policy alone but determine the content of what is taught. A survey of 113 medical schools showed that those institutions where ethnic and sociocultural issues were thought important enough to deserve formal courses in the curriculum were the same that had the highest minority enrollments; those that dealt with the assessment and treatment of minority group members in other courses had median enrollments, while those that had no teaching on sociocultural factors in medicine had the lowest minority enrollments (33). An earlier survey found that successful minority admissions was most closely correlated with modification of admissions procedures to include minority students and faculty (34).

The impact of the political environment is powerful, as can be seen from the list of successful and unsuccessful institutions (Table 3). The city of Newark, site of one of the worst urban riots of the late 1960's, has emerged with a potent minority electorate which has made demands upon its health professional schools (see box by Richard Younge). Similar settings in Chicago, Boston, Detroit, and New York City have not had perceivable impact. The University of Connecticut, on the other hand, was built in suburban Farmington, insulated from Hartford and the mainland's third largest Puerto Rican population; it had no Puerto Rican students in 1976-77 (36). The University of South Dakota, demonstrating the soft money syndrome, states that "we feel that we have a special obligation to Native Americans" (36), while apologizing for having no funds to devote to a specific program. No minority student has attended the school in any class since 1975-76 (32,35)! The University of West Virginia, which has no affirmative action program, special recruitment, or financial aid plans, had one Black medical, two dental, and one pharmacy student enrolled among its 792 health professional students in 1976-77. Eight schools of pharmacy in 1976-77 and five schools of medicine in 1978-79 had no minority students enrolled (32,35). Despite its long-established reputation and 2,000 minority applications each year, Howard still maintains a vigorous recruitment program (37).

West Virginia, LSU, Tennessee, and Nebraska ranked among the worst schools for the enrollment of both women and minorities in medicine and dentistry. Toledo, Wyoming, North Dakota and Idaho State shared this record among schools of pharmacy (Table 3). The institutional attitudes reflected in recruitment and admissions of minorities appear to parallel those toward women and are likely to be equally evident in what is taught about women.

A striking pattern emerges when examining the medical schools enrolling the fewest women. Of the 30 schools with the lowest female enrollments, 21 are located in the southeastern and border states (32). Only one of the predominantly white schools with 30 percent or more women enrolled was in a border state—i.e., Kentucky, Missouri, Tennessee, and West Virginia. None were in the southeastern states in 1978-79 (38). This pattern is present but less prominent for minority enrollment, with 18 of the 33 lowest medical school enrollments to be found in the southeastern and border states (32).

Faculty. The participation of minority faculty and students in the admissions process has been the most important factor identified in successful recruitment efforts, according to a 1972 study (34). Thus, a necessary condition for successful minority and female enrollment must be the recruitment of minority and women faculty. This 1972 national survey found that 65 percent of medical schools admitted that their efforts to recruit faculty had failed; half said that they had failed recruiting minority administrators. Only one percent of the American medical schools reached even 75 percent of their recruitment objective in faculty, while 35 percent noted success in student recruitment and only 11 percent failure (34).

With the increase in minority graduates since that time some improvement in recruiting minority faculty presumably should be seen. Nevertheless, the ivory walls remain white and impenetrable. Although the absolute numbers of Black, Hispanic, and Native American faculty have increased since 1971-72, they represent the same 2.6 percent in 1978-79 as in 1971-72 (see Table 4). Even this standing in place was disproportionately contributed to by the predominantly minority medical schools—Howard, Meharry, and Morehouse. The
Table 3

PLAYING THE 'DOZENS'—AFFIRMATIVE ACTION AND INACTION

BEST ENROLLMENT AND RETENTION

<table>
<thead>
<tr>
<th>Medicinea</th>
<th>Dentistry</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Meharry (86.2)</td>
<td>Meharry (84.0)</td>
<td>Texas Southern* (66.1)</td>
</tr>
<tr>
<td>2. Howard (75.8)</td>
<td>Howard (69.9)</td>
<td>Florida A&amp;M* (59.9)</td>
</tr>
<tr>
<td>3. UC-Irvine (23.3)</td>
<td>UC-Berkeley (21.0)</td>
<td>Xavier* (53.6)</td>
</tr>
<tr>
<td>4. Stanford (19.1)</td>
<td>UCLA (17.5)</td>
<td>Howard (45.2)</td>
</tr>
<tr>
<td>5. New Mexico (19.0)</td>
<td>USC (15.0)</td>
<td>New Mexico (23.8)</td>
</tr>
<tr>
<td>6. UCSF (17.9)</td>
<td>Harvard (12.7)</td>
<td>Michigan (14.7)</td>
</tr>
<tr>
<td>7. CMDNJ-Newark (17.9)</td>
<td>Colorado (11.3)</td>
<td>Texas (14.2)</td>
</tr>
<tr>
<td>8. CMDNJ-Rutgers (17.7)</td>
<td>CMDNJ (11.3)</td>
<td>UC-Berkeley (12.1)</td>
</tr>
<tr>
<td>9. Michigan State (17.4)</td>
<td>M.C. Georgia (11.1)</td>
<td>U. Houston* (14.2)</td>
</tr>
<tr>
<td>10. Baylor (15.4)</td>
<td>Oklahoma (11.1)</td>
<td>Florida (8.4)</td>
</tr>
<tr>
<td>11. North Carolina (15.0)</td>
<td>Michigan (9.1)</td>
<td>Maryland (8.3)</td>
</tr>
<tr>
<td>12. Colorado (14.5)</td>
<td>Texas-SA (8.3)</td>
<td>USC (7.8)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MedicineC</th>
<th>Dentistry</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Med. Coll. PA* (63.2)</td>
<td>Harvard (32.9)</td>
<td>Puerto Rico (75.9)</td>
</tr>
<tr>
<td>2. SUNY-Stony Brook (53.8)</td>
<td>Puerto Rico (26.9)</td>
<td>Michigan (66.0)</td>
</tr>
<tr>
<td>3. Michigan State (37.4)</td>
<td>UCLA (26.6)</td>
<td>Purdue* (53.4)</td>
</tr>
<tr>
<td>4. UCSF (33.9)</td>
<td>Columbia (23.1)</td>
<td>Howard (50.3)</td>
</tr>
<tr>
<td>5. Howard (33.8)</td>
<td>SUNY-Stony Brook (22.2)</td>
<td>Tennessee (50.1)</td>
</tr>
<tr>
<td>6. Missouri-KC (32.9)</td>
<td>Meharry (21.7)</td>
<td>North Carolina (48.9)</td>
</tr>
<tr>
<td>7. Columbia (32.9)</td>
<td>Boston U. (19.6)</td>
<td>Virginia Commonwealth (47.3)</td>
</tr>
<tr>
<td>8. Harvard (31.5)</td>
<td>Howard (19.1)</td>
<td>Kentucky (47.2)</td>
</tr>
<tr>
<td>9. Wright State* (31.3)</td>
<td>Tufts (18.3)</td>
<td>SUNY-Buffalo (46.3)</td>
</tr>
<tr>
<td>10. Tufts (31.1)</td>
<td>Connecticut (16.9)</td>
<td>Maryland (45.9)</td>
</tr>
<tr>
<td>11. UC-Davis (30.9)</td>
<td>Penn (15.9)</td>
<td>UC-Berkeley (44.8)</td>
</tr>
<tr>
<td>12. CMDNJ-Rutgers (30.5)</td>
<td>CMDNJ (15.6)</td>
<td>Illinois (43.4)</td>
</tr>
</tbody>
</table>

number of Black faculty increased 33 percent at Howard and Meharry from 1971-72 to 1975-76 (39), and Morehouse was established in 1977-78. Mainland Puerto Rican faculty membership has actually declined slightly during the decade.

The recruitment of women on faculties of medical schools is only slightly less discouraging, despite the growing number of women enrolled and graduating. Nationally there has been no significant upward movement in the past ten years. In 1965-66 women represented 15 percent of faculty members holding medical degrees; in 1975-76 this was only 9.9 percent (40). Since 1975-76 the percentage of women on medical school faculties has remained just about the same—15.1 and 15.2 percent in 1975 and 1978, respectively. The largest number and percentage of these women faculty members, however, were found in libraries, where women comprised more than 70 percent of the staffs (38).

Women are also disproportionately represented in the lower faculty ranks (see Table 5). There are no women deans, only 4.5 percent associate and 9.9 percent assistant deans, and 1.5 percent department heads, with no significant improvement in these figures during recent years (38).
## WORST ENROLLMENT AND RETENTION

### Under-Represented Minorities (Percent)

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Dentistry</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. S. Dakota (0)</td>
<td>Emory (0.2)</td>
<td>Northeastern* (0)</td>
</tr>
<tr>
<td>2. West Virginia (0.3)</td>
<td>Nebraska (0.4)</td>
<td>Albany (0)</td>
</tr>
<tr>
<td>3. Vermont (0.3)</td>
<td>Marquette (0.6)</td>
<td>Pittsburgh (0)</td>
</tr>
<tr>
<td>4. Hawaii* (0.3)</td>
<td>Ohio State (0.7)</td>
<td>Iowa (0)</td>
</tr>
<tr>
<td>5. Oregon (1.1)</td>
<td>Boston U. (0.7)</td>
<td>U. Toledo* (0)</td>
</tr>
<tr>
<td>6. Albany (1.3)</td>
<td>S. Illinois (0.8)</td>
<td>SUNY-Buffalo (0)</td>
</tr>
<tr>
<td>7. S. Florida* (1.3)</td>
<td>West Virginia (0.8)</td>
<td>Wyoming* (0)</td>
</tr>
<tr>
<td>8. Virginia (1.4)</td>
<td>LSU (1.1)</td>
<td>Washington State* (0)</td>
</tr>
<tr>
<td>9. Tennessee (1.5)</td>
<td>Tennessee (1.3)</td>
<td>Ohio Northern* (0.2)</td>
</tr>
<tr>
<td>10. LSU-Shreveport (1.8)</td>
<td>Minnesota (1.7)</td>
<td>N. Dakota State* (0.3)</td>
</tr>
<tr>
<td>11. Nebraska (1.9)</td>
<td>Indiana (1.8)</td>
<td>Duquesne* (0.3)</td>
</tr>
<tr>
<td>12. Nevada* (2.1)</td>
<td>Louisville (1.8)</td>
<td>Idaho State* (0.4)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Dentistry</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Creighton (12.8)</td>
<td>Tennessee (4.9)</td>
<td>Utah (19.0)</td>
</tr>
<tr>
<td>2. Utah (13.4)</td>
<td>Creighton (5.4)</td>
<td>Idaho State* (20.2)</td>
</tr>
<tr>
<td>3. Texas-SW* (14.1)</td>
<td>Nebraska (5.4)</td>
<td>Oklahoma (23.4)</td>
</tr>
<tr>
<td>4. LSU-Shreveport (14.6)</td>
<td>Missouri-KC (5.5)</td>
<td>Wyoming* (23.4)</td>
</tr>
<tr>
<td>5. S. Alabama* (14.8)</td>
<td>S. Carolina (5.6)</td>
<td>Brooklyn* (24.1)</td>
</tr>
<tr>
<td>6. S. Carolina (14.9)</td>
<td>Georgetown (5.7)</td>
<td>Ferris State* (25.1)</td>
</tr>
<tr>
<td>7. Tennessee (14.9)</td>
<td>Baylor (6.1)</td>
<td>New Mexico (26.2)</td>
</tr>
<tr>
<td>8. Miami* (15.3)</td>
<td>Emory (6.2)</td>
<td>NE Louisiana* (26.2)</td>
</tr>
<tr>
<td>9. Minn-Duluth* (15.3)</td>
<td>SUNY-Buffalo (6.7)</td>
<td>U. Toledo* (26.6)</td>
</tr>
<tr>
<td>10. Oklahoma (15.5)</td>
<td>West Virginia (6.7)</td>
<td>St. John’s* (26.8)</td>
</tr>
<tr>
<td>11. Uniformed Serv.* (15.6)</td>
<td>Temple (7.0)</td>
<td>Samford* (Ala.) (27.9)</td>
</tr>
<tr>
<td>12. St. Louis (15.8)</td>
<td>Northwestern (7.3)</td>
<td>N. Dakota State* (28.3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Dentistry</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. West Virginia (15.9)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Indicates no other schools affiliated (e.g., an independent medical, dental, or pharmacy school). Italics indicate the appearance of the school in another best or worst category in this chart, indicating the frequent consistency and crossover between minority and women and between different schools (e.g., Howard appears in all best columns).

Source: Philpat, Wilbertine P., Minorities and Women in the Health Fields: Applicants, Students and Workers.


Footnotes:

a More recent data from the 1978-79 academic year show virtually no change in the leading seven predominately white medical schools with only slight changes in their order and only two changes in the top ten such schools. (See Gapen, Phyllis, "Minority Admissions: The Increasingly Empty Promise of Affirmative Action," The New Physician 28: 20-24, July/August 1979).

b More recent data for the 1978-79 academic year demonstrate that five medical schools had no minority students enrolled, including two newly opened schools. The dozen worst schools were virtually identical to those of 1976-77 with the addition of three newly opened schools. (See Gapen, Phyllis, "Minority Admissions: The Increasingly Empty Promise of Affirmative Action," The New Physician 28: 20-24, July/August 1979).

c More recent data from the 1978-79 academic year demonstrate the stability of these rankings. The six medical schools with the highest percentage of women enrolled remained the same with slight changes in order. Ten of the top twelve schools were among the top sixteen in 1978-79. (See Braslow, Judith B., "Current Status of Women in Academic Medicine," paper presented at Regional Conference on Women in Medicine, New York, March 24, 1979).
Table 4

Minority Representation on U.S. Medical School Faculties, 1971-72 to 1978-79

<table>
<thead>
<tr>
<th></th>
<th>1971-72^a</th>
<th></th>
<th>1975-76^a</th>
<th></th>
<th>1978-79^b</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Caucasian</td>
<td>27,005</td>
<td>77.9</td>
<td>33,345</td>
<td>82.0</td>
<td>38,641</td>
<td>82.0</td>
</tr>
<tr>
<td>Black</td>
<td>565</td>
<td>1.6</td>
<td>733</td>
<td>1.8</td>
<td>820</td>
<td>1.7</td>
</tr>
<tr>
<td>Native American</td>
<td>11</td>
<td>t</td>
<td>14</td>
<td>t</td>
<td>22</td>
<td>t</td>
</tr>
<tr>
<td>Mexican American</td>
<td>54</td>
<td>0.2</td>
<td>74</td>
<td>0.2</td>
<td>89</td>
<td>0.2</td>
</tr>
<tr>
<td>Puerto Rican</td>
<td>263</td>
<td>0.8</td>
<td>276</td>
<td>0.7</td>
<td>320</td>
<td>0.7</td>
</tr>
<tr>
<td>Other*</td>
<td>2,432</td>
<td>7.0</td>
<td>3,622</td>
<td>8.9</td>
<td>3,445</td>
<td>7.3</td>
</tr>
<tr>
<td>Unknown</td>
<td>4,328</td>
<td>12.5</td>
<td>2,618</td>
<td>6.4</td>
<td>3,803</td>
<td>8.1</td>
</tr>
<tr>
<td>Total</td>
<td>34,658</td>
<td>100.0</td>
<td>40,682</td>
<td>100.0</td>
<td>47,140</td>
<td>100.0</td>
</tr>
</tbody>
</table>

†less than .05%
*includes other Spanish surnames, Asian, and Pacific origin

Sources:


The largest single rank of women faculty is professor emeritus (13 percent), a tribute to an earlier era in the women's movement (41). To make these matters worse there was between a $600 and $1000 difference in salaries between men and women at the same rank noted as recently as 1975, although such salary differentials have been illegal in higher education since 1972 (40). One study at UC-San Francisco found a $7000 difference between male and female doctors of the same experience and productivity (42). An HEW study commissioned in 1976 "did not find

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Table 5

Distribution by Rank of Male and Female Full-Time Medical School Faculty, 1976

<table>
<thead>
<tr>
<th>Rank</th>
<th>Percent of All Males</th>
<th>Percent of All Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor</td>
<td>28%</td>
<td>8%</td>
</tr>
<tr>
<td>Associate Professor</td>
<td>23%</td>
<td>16%</td>
</tr>
<tr>
<td>Assistant Professor</td>
<td>32%</td>
<td>36%</td>
</tr>
<tr>
<td>Instructor</td>
<td>8%</td>
<td>22%</td>
</tr>
<tr>
<td>Clinical Ranks</td>
<td>3%</td>
<td>4%</td>
</tr>
<tr>
<td>Lecturer and Other</td>
<td>6%</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source:
affirmative action efforts to be either significant or widespread" for women in all the health professional schools (19). Apparently health professional schools are more generous with seats in their classrooms than at their lecterns or in their laboratories!

The attitudes of Blacks and whites on why there are not more minority or women faculty in the medical schools are dramatically different. Among the faculty, fellows, house officers, and students polled at the University of Michigan, only one-third of Black respondents thought too few Black faculty were available, while 90 percent of whites believed this. All the Black students thought the attitudes of white faculty and housestaff turned prospective minority candidates off, while less than half the white respondents agreed with this (43). Throughout the survey, on almost every issue examined, Blacks and whites had almost opposite views (43). Blacks viewed whites' attitudes opposite to the way whites viewed themselves. Solutions proposed by predominantly white institutions for underrepresentation, if this study is any indication, are likely to embody attitudes sharply different from those of the minorities whom they are trying to recruit—unless there is considerable minority participation from its onset. This "designed-to-fail" Catch-22—where without minority members, minority cannot be successfully recruited—suggests another reason why so many "good faith" efforts have had such limited results.

"There is no evidence that women or minority members would better serve the health needs of the nation than white males."

Despite numerous studies to the contrary, many

**Minority students not only bear the burden of racial and cultural barriers to parity in the health professions, but disproportionately that of class. The controversy over admissions standards seems not to be one of maintaining quality but rather maintaining race and class in health academia still maintained that they cannot predict (and, thus, select) those applicants most likely to enter primary care in underserved areas in rural and inner city America. Typical of this attitude, L. Thompson Bowles, a dean at George Washington University School of Medicine, said, "Medical schools are not very good at picking and predicting which students will elect careers in underserved areas...none of us knows how to identify such students consistently" (7). Numerous studies in the 1950's and 1960's demonstrated conclusively the importance of rural rearing for physicians and their spouses who settle in small town and rural practices (44). The location of the physician's medical school and post-graduate training was repeatedly demonstrated to influence those who choose urban practices (44). White M.D.'s tend to establish practices among their ethnic group of origin, away from low income and non-white populations (15). Surveys of Black physicians show that they are relatively concentrated in general and family practice and other primary care specialties (46-48), and in practices which serve Black, economically disadvantaged, and inner city patients (49). Eighty-five percent of recent Black dental graduates in California had 50 percent or more minority patients, and 80 percent of those in Los Angeles and Alameda counties, more than half of the graduates, were located in or adjacent to federal shortage areas (45). Howard and Meharry graduates are three times more likely to serve in large municipal hospitals that serve mostly minority populations (47). Among physician assistant students, 35 percent of Black students, compared to one percent of white students, identified inner city ghettos as their anticipated practice choice; half the

**HEW has been criticized for its reluctance to issue show-cause notices to non-compliant institutions. From 1971 to 1974, only two were issued**

Continued on Page 25
HEALTH AND HOSPITALS IN CRITICAL CONDITION

On September 28th, the employees of the Health & Hospitals Governing Commission in Chicago were notified of a paycheck freeze. That, as it turned out, was to be only the beginning.

Two weeks later, the hospital's employees were again faced with a payless payday. An angry meeting of 1000 workers voted to take patients waiting in County's Emergency Room to Rush Presbyterian St. Luke’s—the wealthy private medical center across the street. The action, one of a series of large militant demonstrations this fall, dramatized the crisis at Cook County Hospital and the failure of private medicine to care for the people of Chicago.

This fall's crisis at Chicago's only public hospital was the product of a growing funding shortage and political conflict over the hospital's governance. Since 1969 when control of the hospital was taken away from the city's powerful Democratic machine, the hospital's independent Governing Commission has been under attack. Although unpopular during its early years for its anti-union policies (precipitating lengthy housestaff and nursing strikes), firing of outspoken doctors, and willingness to cut back the size and services of the hospital, the Governing Commission had recently become increasingly responsive to the community's interest.

Under the Commission's direction, the hospital regained full J.C.A.H. accreditation, opened a series of neighborhood clinics, successfully recruited high quality housestaff trainees, especially minorities, and wiped out the legacy of a century of patronage practices. The composition of the Board had become predominantly minority. While its independence and accomplishments were a source of irritation to the local politicians, its refusal to make deeper cuts in the hospital was unacceptable. This led to the ousting of the Governing Commission. Effective December 1, 1979, control of the hospital returned to the Cook County Board and its president, George Dunne (who succeeded Mayor Daley as the head of the Democratic party).

The underlying problem is a familiar one. The nationwide assault on public healthcare is shamefully obvious in the Medicaid eligibility figures for Cook County Hospital for the past five years. In 1973, 62 percent of those receiving care had their hospital bills paid by Medicaid. By 1979, only 27 percent were eligible for Medicaid reimbursement. This resulted in a 40 million dollar deficit for the hospital's fiscal 1979 budget; meanwhile the state accrued a public aid surplus of 100 million dollars annually for each of the

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September 28, 1979

MEMORANDUM

TO: ALL EMPLOYEES
FROM: JOHN W. B. HADLEY, CHAIRMAN
HEALTH & HOSPITALS GOVERNING COMMISSION
SUBJECT: NOTICE CONCERNING YOUR NEXT PAYCHECK

Because of the continuing inflation and the increasing numbers of patients who are unable to pay their medical bills promptly and have no insurance or public aid, the Commission's finances have become increasingly strained. Unless we can get the County of Cook to agree to our borrowing money, we will have to defer the paychecks which will start to be handed out on the P.M. Shift, Tuesday, October 2.

This is one more event in a long history of under payment to the Hospitals the Commission runs. You are aware of the layoffs and other steps taken over the last years to keep the Hospitals open, make your jobs secure and avoid these crises. The Commission realizes that the Hospitals are now understaffed for the number of patients we serve. This continued understaffing and underpaying must be stopped so that the sick can be properly cared for.

The Commission will continue to try every means to get money to pay the deferred paychecks and pay them as soon as possible.
past three years.

The denial of Medicaid benefits to an increasing number of Cook County Hospital's patients is achieved through a series of restrictive policies by the State of Illinois. The most glaring is the frozen level of Medicaid certification. A family of four earning more than $4,200 or an individual making $1,800 annually are too rich to qualify. This group of patients, euphemistically dubbed "self paying," has grown from 8.7 percent of patient days in 1973 to 40.6 percent in 1979.

The specter of closing Cook County Hospital is a real one. The idea has repeatedly been proposed by members of the County Board. It has been advocated by representatives of the private hospitals who have dominated Chicago's HSA. In fact, the HSA plan on the future of health care in Chicago neglected to even mention Cook County Hospital. A major victory of the movement defending the hospital this fall had been a concession by Governor Thompson, Mayor Byrne and George Dunne that the hospital will remain open.

However, the recklessness with which these politicians have allowed repeated delayed paychecks created widespread insecurity and resignations in the hospital. The lack of support for the stability and long term needs cripples the function of the hospital, slowly destroying it. For example, almost one-third of the nursing positions in medicine are unfilled, and the medical ICU has been cut 50 percent to only 10 beds.

The critical condition of the hospital was evident to the workers inside who responded with unprecedented activism to defend the hospital. Hundreds of thousands of petition signatures were collected, frequent demonstrations of 500-1,000 people, and formation of a joint crisis center by the hospital's unions were manifestations of the workers' involvement in the struggle. Their concern went well beyond the delayed (but so far always paid) paychecks, and the need to organize the community to defend the threatened services was always the primary goal.

The inability to mobilize large numbers of people from the community has been frustrating. Black housestaff who led the struggle this fall advocated the closure of the Emergency Room to emphasize our inability to adequately care for the patients. The dilemma of demonstrating how bad conditions are, while at the same time struggling to provide decent care under increasingly difficult conditions, has made tactical choices difficult.

Cook County and its clinics deliver over 750,000 patient visits annually to an estimated 200,000 people. But County's constituency is a much larger one. Its problems are not simply those of an underfunded public hospital, but are the contradictions of our private health care system. The increasing monopolization by private medical centers threatens everyone's right to health care. By imposing their definition of "sound management"—maximization of income through expanding revenue generating procedures and minimizing care to those unable to pay—they guarantee skyrocketing health inflation and increasingly inaccessible services.

The ultimate success of our movement to save Cook County Hospital hinges on our ability to make the connection between this savage attack on the health of minorities and poor people, and the costly unresponsive health system that most people encounter. Only a public health care system has the potential to solve these problems and genuinely reorganize health resources to meet people's needs.

—Gordon Schiff and Mardge Cohen

For more information write Residents at Cook County Hospital and the Committee to Save Cook County Hosp., 201 S. Ashland, Chicago, Ill. 60607
Environmentalists worked hard during the early seventies to get the pesticide aldrin off the US market. Finally, in 1974 the Environmental Protection Agency banned aldrin as a potent carcinogen. Shell Oil responded to the ban by shifting its production of aldrin from California to a plant in the Netherlands and then proceeded to dump the poison in Third World countries, including Brazil. In 1975, the year after the US ban, thirteen village children in Bahia, Brazil died from eating aldrin-contaminated food. And yet today aldrin is sold like flour to unsuspecting farmers in open village markets from Brazil to Indonesia.

In Guatemala, cottonfields are sprayed from the air 40 to 50 times a year with a smorgasbord of US-made but US-banned pesticides. Children of tenant farmers are used as “flagmen” to indicate target fields. The death of children from acute pesticide poisoning is not considered unusual.

When researchers discovered that Tris, a flame-retardant used to treat children’s sleepwear, causes cancer, the US government clamped down on sales (a passing irony since the government had earlier ordered manufacturers to use Tris). Despite the ban, millions of children in Asia, Africa and Latin America sleep in contraband clothing thanks to the clandestine cooperation of corporate dumpers, sleazy middlemen and governments.

Dumping hazardous substances, processes, and machinery onto unregulated markets overseas is big business—an estimated $1.2 billion of unsafe goods every year—and dumping may well emerge as a growth industry in the eighties. It may also be the “corporate crime of the century”, as Mother Jones magazine claimed in a recent exposé. (Nov., ’79).

Dumping the Dumpers?

What’s being done to dump the dumpers? Virtually nothing. The President, the regulatory agencies and the Export-Import Bank take the position that what’s unsafe for you and me is fair game for anyone else in the world, as long as our balance of payments is bolstered. If we are to protect human life and the global environment from the latest version of the corporate free-for-all, we must consolidate the gains of the seventies in environmental regulation and then move aggressively to forge alliances with progressive forces in labor and the environmental movements around the world. A tall order.

But it should be seen these arguments for what they are. For the last decade, critics of toxic substance control have told us that we must choose between our health and our jobs, between environmental quality and a higher standard of living, or between product safety and competition in international markets. A broad coalition of groups refused to accept that false dichotomy and instead demanded gainful and healthful employment as a human right. Now we are told that poor people in the Third World must accept those grim “choices” we refused. This amounts to environmental blackmail wherever it’s played, and it’s clear that if indus-
tries in the developed countries are allowed unfettered movement in the Third World, the same vicious cycle of occupational death and environmental degradation will be repeated. Speaker after speaker rose to relate the industrial nightmare of asbestos and benzene, vinyl chloride and benzidine dyes, transplanted to Asia and Latin America with the same fatal conclusion. They spoke of countries with little or no regulation, marginal enforcement capability, no labelling requirements, inadequate toxicity information on hazards from the country of origin and a weak union movement whose members know no

Industry would have us believe that a little less regulation at home will lead to a lot less dumping abroad. But most people came away from the conference convinced that the best way to protect comrades in poor countries is to strengthen regulation over our own hazardous industries. Third World activists see the American struggle as much closer to victory than their own, partly because our environmental legislation can be utilized to force technological changes in industrial production that will lead to safer jobs and safer places to live—and, presumably, to less toxic material to dump.

**Capital Flight**

Take the hotly debated question of capital flight. When the giants in the asbestos industry took up their marbles and moved south to friendlier climes, environmentalists worried that this would set off a stampede to dot the globe with Western-owned, polluting plants. This is an understandable concern, but a close look at direct US investments abroad during the seventies does not show a massive flight of capital.

For example, the chemical industry faces heavy regulatory pressure under the Toxic Substances Control Act, and you would expect to see substantial movement of firms if the capital-flight thesis holds. But a paper presented by Dr. Martha Ventilla of the U.N. Environmental Program showed that while a few chemical firms have fled the country, new firms have moved into the vacuum by introducing technological innovations that are both cost-effective and meet more stringent regulatory standards. Ventilla argues that though the chemical industry will fight regulation tooth and nail, the trend in the US and other industrial countries is toward changes in chemical process technology and the development of substitute products. This amounts to internalizing the social costs of chemical exposure to the worker.

Herman Rebhan, General Secretary of the International Metalworkers’ Federation, announced at the conference that the International Metalworkers Federation (IMF) plans to hold a public international tribunal in Geneva to examine the export of hazardous work that will call for new laws to stop the export of hazardous processes and criminal penalties for offending companies and their executives. IMF is one of the few internationals which has made a full commitment to worker education on occupational hazards. Next year, IMF will offer training courses to more than 15,000 union officials and shop stewards in the Third World. To back up its commitment, IMF has called for a worldwide ban on the production and use of asbestos, a move that will affect many of its members.

In his talk Rebhan most clearly expressed the central message of this conference, “It will not be long before the people of the Third World revolt against being treated as the garbage can of the advanced industrial world.”

—Joseph Hunt

(Joseph Hunt is a lecturer in biology and social studies at Harvard University.)
By virtue of the sheer weight of demographics, it was inevitable that agism would become a feminist issue. Gender has the most obvious impact upon life expectancy in this country. In 1975 the average life expectancy for US women was 7.8 years longer than for men and almost one year longer still for non-white women than non-white men. Gains in longevity over the last sixty years have widened these differences. In 1920 life expectancies for men and women were 53.6 and 54.6 years, respectively, only one year's difference. By 1975 these had grown to 68.7 and 76.5 years, respectively. This might be considered an advantage were it not the treatment of older Americans so deplorable. Not only are women more likely to spend a longer period suffering the society's disdain for its own future, captured in its embarrassed euphemisms—"senior citizens," "the elderly," "the aged," "older Americans"—but women are more likely than their male siblings and husbands to be delegated the responsibility of caring for aging family members whose independence or health begins to fail. The decennial re-discovery of profiteering and abuse in nursing homes has become a collective penance ritual.

The effects of aging are compounded by poverty. Women have always been poorer than men, and this problem has grown worse since the New Frontier, the Great Society, and the War on Poverty. In 1959 the rate of poverty among females was two-and-a-half times greater than the rate for males. By 1975 the female poverty rate had grown to four-and-a-half times the male rate. The percentage of persons 65 years or older with incomes below the poverty level is almost twice that of all families in 1975. This persists despite the 41 percent decline of impoverished elderly between 1969 and 1976 and the evidence that over half of those who have escaped from poverty (as a statistic) since 1966 have been over 65 years old.

The Gray Panthers' Task Force on the Older Woman has determined financial integrity of the older woman as their first and primary objective. Only recently mainstream feminists have re-discovered the importance of the family and raised the question of our futures, sanctioned by the N.O.W. Legal Defense and Education Fund convening the National Assembly on the Future of the Family in November in New York City. Yet, it has been the Gray Panthers and Robert N. Butler, director of the National Institute on Aging who have been most critical of public aging policies based largely on research on men (by men), whereas most of the elderly are women.

In 1974 by a then 39 year old senior at Trinity College in Illinois. Geraldine Cannon, a mother of five (and grandmother, according to Time) and a surgical nurse at Skokie Valley Community Hospital outside Chicago, applied to the University of Chicago and Northwestern medical schools but was told that candidates over 30 had little chance for admission. (Remember, "Don't trust anyone over 30"?) When she was not admitted, Cannon complained to HEW. Under Title IX of the Civil Rights Act and its 1972 education amendments, HEW is responsible for enforcing the ban against sex discrimination in admissions and student affairs in schools receiving federal funding. She and her attorney husband reasoned that such age bias discriminated against women who were more likely than men to defer their education to raise a family or to come to medicine, as she had done, through another career like nursing.

HEW has a backlog of some 3,500 discrimination complaints, about one-quarter of which involve Title IX sex discrimination cases (the bulk of which are Title VI race discrimination charges). Cannon's complaint promptly disappeared in HEW's red-tape jungle. So she took her case to federal court. Both the lower court and the court of appeals told her she did not have the right to sue and that only HEW had the right to enforce the Civil Rights Act. HEW has always been extremely reluctant to do this, since its only legal sanction is to deny all federal funding to a school. Earning the reputation, ironically, as a feminist Allan Bakke, Cannon took her case to the Supreme Court.

In May 1979 the Supreme Court ruled 6 to 3 that Ms. Cannon did, indeed, have the right to bring suit in court against the schools which had denied her...
admission. The Court found an "implied right" for individuals to sue educational institutions in court for sex discrimination. This was applauded as a victory by feminists, one which will also make racial discrimination suits easier. Although others have brought suits under both Title VI and Title XI before and many courts and civil rights lawyers have assumed that this avenue was open, the Supreme Court ruling makes it a right. Now Cannon's suit against Northwestern and the University of Chicago is in court.

While Cannon argues that her test scores and grades were higher than many of those admitted to the two medical schools in 1974, University of Chicago Dean Robert Uretz maintains that even with this confirmed right to sue, she will not be admitted because among 5,427 applicants, 2,000 had better academic credentials than Ms. Cannon. Dean Uretz claims this approach to admissions will hurt minority candidates who tend to score lower on entrance exams than whites. He also places little faith in the courts finding fair solutions. How quickly those representing the institutional interests pit women against minority students!

While the media's coverage largely overlooked the importance of age bias in medical school admissions, its importance was not lost on HEW. A month after the Supreme Court's decision then-Secretary Joseph Califano issued regulations to take effect July 1, 1979, banning age discrimination in all federally financed programs, including medical schools, based upon a 1975 law. The regulations, however, received criticism from senior citizens' groups because numerous loopholes permit Congress, states, and local groups to approve exceptions. The current law already permits age distinctions that assure a program's "normal operations" or those based on "reasonable factors other than age," so in reality very little must change. The regulations did not even affect the only medical school operated by the federal government—the Uniformed Services University of the Health Sciences. This school, administered by the Department of Defense, has a written policy which discourages applicants over 28 years because of the fewer years of active duty after graduation.

The problems of older candidates cited to justify their exclusion are the very same problems identified by critics of medical education in general—the difficulty adapting to its lock-step rigidity, inappropriate competition, and moral and social isolation from the world of family and human values. The demands of its full-time and night-call schedule exclude anyone with significant financial or family commitments. Although older candidates are obviously further from their test-taking and college science courses, grades and test scores are still invoked as admissions criteria—yet a University of Missouri study has shown that the complex of maturity, rapport, and motivation is a better predictor of total medical school performance than are grades.

Test scores, however, are known to reflect social class and parental income. Admissions follow a linear correlation with family income. Thirty-two point eight (32.8) percent of applicants with parental income less than $5,000 and 49.2 percent with family income greater than $50,000, were admitted to the class of 1976-77. Older applicants seem to be more likely to come from other careers and less affluent backgrounds, so age bias functions effectively as class bias as well as sex bias. Without a career ladder the health care system transforms class into caste. Individual mobility and the value of clinical experience are denied. There are no bootstraps on the bedpans.

The demands of medical training, its rigors, isolation, and relocations parallel the corporate career where executives are arbitrarily transferred from office to office, city to city, to prevent the development of loyalties to any community except the corporation itself. It is no wonder that the medical profession does not want older students whose loyalties have formed and who will not belong solely to the corporation.

Ten years ago, perhaps, the greatest difference between qualified men and women who applied to medical school was their response to rejection. Most men would reapply after obtaining laboratory or hospital jobs or getting another degree with the support of their families and friends; most women would seek another career. Today, that has clearly changed. The women's movement and the persistence and determination of women such as Geraldine Cannon have made a second chance at a new right.

Just below the surface of these feminist issues are those of age and class discrimination. Racism was recognized in the 1960s, sexism in the early 1970s, and agism in the late 1970s. Progress in affirmative action in the 1980s may require the real discovery of class and its interrelation with race, sex, and age. Perhaps we have run out of closets to empty.

—Hal Strelnick
"HUMAN RIGHTS" FOR FNGs

Last year, an organization called the Commission on Graduates of Foreign Nursing Schools (CGFNS) was formed by the ANA, the NLN, and DHEW. Its avowed purpose was to prepare and administer a voluntary nursing and English proficiency test to foreign nurse graduates (FNGs) in their home countries as a screening process before their coming to the US. Weeping great crocodile tears for the poor super-exploited FNG in the US, the CGFNS proposed its own solution—keep them all out but the most "worthy."

At the time of its formation, the CGFNS had no more authority than any other commission which the professional associations are so fond of setting up; but this time there was a difference. The desire of the professionalists to exclude as many FNGs as possible dovetails nicely with the isolationist national chauvinism of the Carter Administration's "Human Rights" campaign.

As we predicted a year ago, the Immigration and Naturalization Service (INS) is moving to adopt the CGFNS exam as a legal prerequisite for entry into the country (1). Thus the circle is complete.

Most FNGs come to this country on what is known as an "H-1" visa. Holders of H-1 visas are considered non-immigrants, which means they have no resident status. These visas are only given to skilled workers, professionals, or others "who (is) of distinguished merit and ability and who (is) coming temporarily to the United States to perform services of an exceptional nature requiring such merit and ability" (2).

As the system works now, institutions in the US recruit FNGs in their home countries, sometimes through commercial headhunters. Once the nurse is recruited, it is the institution which applies for the H-1 visa for the nurse, in effect "sponsoring" his or her entry into the country. Since the right to remain in the country is solely based on that particular job, the power of the institution over the FNG is almost unlimited.

If the nurse should fail to pass the State Boards after arriving s/he may lose the visa. FNGs are not allowed to change employers within nursing without repeating the entire process. Literally any variations of the terms of the visa are grounds for its revocation, and the FNG becomes an undocumented—or as the Yellow Press likes to call it, "illegal"—alien.

Hospitals use their positions of power over FNGs to good advantage. Where union organizing drives are taking place, the hospital need only remind them of their vulnerability in order to herd them to the polls to vote "No Union," or at least to remain silent. FNGs are frequently paid at lower rates of pay for extended periods of time, while performing the same duties. Air fare, housing, other recruitment expenses and interest may be deducted from their pay, reducing them to a virtual state of peonage. FNGs may be denied experience, or degree, differentials (3). If they should fail to pass the State Boards, FNGs may be forced to work as LPNs or nurses' aides, if they can somehow manage to avoid deportation.

Since the right to remain in the country is solely based on a particular job, the power of the institution over the foreign nurse graduate is almost unlimited

FNGs have a very real problem with the State Boards. Proponents of the CGFNS exam justify it by pointing to the high failure rates of FNGs. Language is claimed to be the major difficulty. To "deal" with this problem, the CGFNS exam is well-suited: It is basically a test of English rather than of nursing. It is truly ironic that the professionalists, who blow so hot over nursing education and nursing excellence, should relegate it to a low priority when evaluating the FNG for practice.

Most FNGs come from countries where English is not the national language. In 1973, for instance, 56.7 percent of all FNGs entering the US came from Asia (4). Of those, Filipino and Korean nurses...
constitute the largest national groups. While statistics are bandied about to show that few FNGs pass the State Boards on their first try, this is not true for FNGs taking the State Boards multiple times. According to DHEW's own figures, between July 1972 and February 1974, 64.1 percent of Korean nurses ultimately passed in that period, and 60.0 percent of Filipino nurses, while only 45.6 percent of those from the British Isles passed (5)!

These figures, when compared with first try failure rates as high as 95 percent would seem to indicate that as a working knowledge of English is acquired, FNGs have no significantly greater problem passing the State Boards than do domestic nurses. If this be the case, it seems grossly unfair to deny FNGs the opportunity to gain that experience by placing added roadblocks to their entry.

While few working nurses would countenance such Draconian measures as the CGFNS/INS connection, many are disturbed by the passivity and apparent political backwardness of many FNGs. American nurses must educate themselves to the difficulties faced by FNGs and develop a sensitivity to their unique problems. FNGs can never become part of the activist nurse movement as long as the knife of deportation is at their throats (6).

It must also be remembered that many FNGs come from countries ruled by dictatorial regimes—all great friends of the United States. Deportation for union or political work could have the most serious consequences.

American nurses and unions should begin developing a program of protections for FNGs so that there may be unity in action. Such a program should include:

- Abolition of the CGFNS and its exam. FNGs should have no more hoops to jump through than any other nurse. There are plenty of jobs for all.
- Cut the hold of hospitals on FNGs by granting them resident immigrant, rather than non-immigrant, status. FNGs should have the right to quit, and to change, jobs.
- International reciprocity for equivalent nursing education, to be administered by an international agency such as the World Health Organization.
- Long-term temporary licensure for those without equivalent education, with the employer or the state to provide nursing refresher courses and English courses.
- Full democratic rights for FNGs. No deportation, or threat of deportation, for union or political activity.

—Glenn Jenkins

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5. DHEW, Survey of Foreign Nurse Graduates, 1976, Table 13.
6. For an excellent treatment of the entire FNG problem, see, "Licensure and Foreign Nurse Graduates: A Struggle for Fairness and Equity," which may be obtained from: National Alliance for Fair Licensure of Foreign Nurse Graduates, P.O. Box 960, Woodside, N.Y. 11377.
**Bakke-ing Up**

Continued from Page 16

Blacks from large cities anticipated ghetto practices (50).

Women and Blacks indicated significantly more interest in practice in physician shortage areas than men and whites, respectively, with similar but less dramatic trends for primary care in general (5).

The relationship between socioeconomic class and specialty practice choice is perfectly linear. Janet Melei Cuca of the AAMC noted, “The connections between income, education, and occupation have been so well established in the sociological literature as to have become almost axiomatic” (51). A direct relationship has been found between family income and both primary care specialty choice and interest in a physician shortage area, the higher the family income the more likely the choice of specialization and the less likely the interest in a shortage area practice. This was true both within and across ethnic and sex groups. Those anticipating larger debts on graduation consistently showed greater interest in physician shortage areas than those anticipating no debt (5). More recent data confirm the continuation of these trends (52). There can be little doubt at this point that admitting greater numbers and percentages of women and minorities, especially from disadvantaged backgrounds, will result in greater numbers of primary care practitioners locating in underserved communities. This is particularly important for those communities where access to care is also limited by cultural or language barriers—in the barrios, the China-towns, the “J-towns,” and on and off the reservations.

“The federal government is doing everything in its power to support affirmative action in the health professions.”

At the request of Congressman Ronald Dellums of California, the General Accounting Office investigated HEW’s record on affirmative action. The GAO concluded that HEW had “made minimal progress in making sure that colleges and universities have acceptable affirmative action programs,” having failed to send “show-cause” notices or begin sanctions against noncomplying institutions, conduct pre-award reviews, or enforce even publicized plans (53). The House Subcommittee on Equal Opportunity found academic institutions to deserve no special exemption from the Executive Orders which regulated federal contracts and noted that enforcement of equal opportunity had been ineffective and federal contract compliance deficient. The U.S. Commission on Civil Rights found in 1975 that “the inadequacy of HEW’s enforcement effort...permits the continuation of practices which result in the denial of equal education and employment to women and minorities.” HEW was again criticized for its reluctance to issue show-cause notices to non-compliant institutions; from 1971 to 1974 despite uncovering numerous violations, only two such notices were issued. HEW repeatedly accepted the assurances of institutions and “plans for a plan” rather than the accepted standard of a documented plan for affirmative action (54). Jack Hartog, an attorney for the Commission on Civil Rights, called the HEW affirmative action effort “a disaster” and noted that it has been reorganized only recently. HEW does maintain an Office of Health Resources Opportunity, but its activities did not even merit discussion in the General Counsel’s review of the department’s activities in light of the Bakke decision (55).

This does not even address the issue of the quality of data collected. The problem arises because the date necessary to monitor affirmative action programs are gathered from the institutions to be regulated and contain many subtle and hidden biases. Just one example is the AAMC’s inclusion in first year enrollments all repeating minority students, rather than just newly enrolling and matriculating students, which inflates the apparent size of the “in-coming” minority students by ten to twenty percent most years (3; see also first article in this series). This not only misleads but results in overlooking some remarkable findings—that 17 percent of minority students offered admissions in 1973–74 to medical schools failed to enroll, something which has never occurred to this extent among white acceptees (3). Some 224 qualified and admitted minority applicants just disappeared, and no one asked any questions because they were “lost” in the statistics!

The U.S. Congress, as we have seen, also tries to weaken affirmative action with various amendments and anti-bussing riders. An HEW-commissioned study on women in the health professions concluded that the Congress’ health manpower actions “seem not to consider, as a matter of course, their possible or probable impact on the entry or practice of women in the professions. . . . We found that some elements of these policies counter much of the intent of affirmative action retention efforts—that is, the weight of manpower policies is far greater in impact than the weight of affirmative action efforts” (21). This, of course, is just as true for minorities. That is, health man-
Scarpelli v. Remson—The Case

Although the dust has only just begun to collect on the amici curae and briefs submitted for the Supreme Court's consideration of Bakke v. Regents of the University of California, a new onslaught on affirmative action in education has begun in the courts of Kansas. The case of Scarpelli v. Remson has been heralded as the “Bakke case of the 1980s” by Gerald C. Horne, Director of the Affirmative Action Coordinating Center in New York.

Scheduled to begin trial before Judge William Meek in Wyandotte County District Court in Kansas City, the case has received little publicity beyond the Midwest, despite the drama and pathos which has already attracted film producers interested in making the story into a movie. Five years ago four Black students—Charles Floyd, Nolan Jones, Charles Lee, and Ernest Turner—received a pattern of racial discrimination at the hands of Dr. Dante Scarpelli of the Pathology Department of the University of Kansas Medical Center. With the assistance of Affirmative Action Officer Chester Rempon, they filed a complaint with the school, charging Scarpelli with “willfully and unlawfully” violating the Civil Rights Act of 1964 in his efforts towards “systematically eliminating them from medical school.”

Evidence of Dr. Scarpelli’s views are on the public record, as he had published an article on minority admissions to medical schools in the New England Journal of Medicine in April, 1975. In that article he charged that medical schools were employing a “double standard” for the admission and education of minority students, whose “only hope of survival depends upon subsequent lowering of academic performance standards, a deplorable practice not only because it is the most despicable facet of the double standard, but also because it makes a mockery of the educational process.” He maintained that the public would be harmed by affirmative action.

The mockery, however, was made in the proceedings which followed. The school denied the students a role in selecting the panel which would hear the charges or determining the procedures which would govern the hearings. The university also “neglected” to inform the four students that Scarpelli would have legal counsel—the university’s own lawyer. When the students stormed out of the proceedings in protest, the charges were dismissed.

Dr. Scarpelli quickly filed a $200,000 libel suit against Remson and the students. A lone Black woman “hung” the first jury. Scarpelli, now at Northwestern University Medical School, has refiled the suit which was scheduled to begin October 29, 1979. Already the case has taken on tragic proportions, as the relentless pressures of the case over five years has led to severe psychological consequences for Chester Remson, who, according to Horne, will be “unable to participate effectively at the trial.”

The implications of the case are quite clear. If the case is lost, women and minority students would become even more reluctant to protest racial and sexual discrimination in the classroom for fear of expensive libel suits. If Scarpelli were to win, his claims about the harms of affirmative action would be supported by the courts.

Time has proven a more revealing judge. All four students are now house physicians in some of the most prestigious hospitals in the country.

Sources: New England Journal of Medicine, April 17, 1975; Affirmative Action Coordinating Center. —H.S.

power and affirmative action needs are not contradictory, they are complementary.

The specific solutions chosen for resolving the specialty, geographic, and language/culture mal-distributions have served to exacerbate rather than resolve minority and women’s underrepresentation in the health professions. This is, unfortunately, the natural consequence of the class interests and ideology of the federal government, the health professions, and their academic institutions. Their myths are designed to disguise genuine contradictions and create them where they have never existed.

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**Scarpelli v. Rempson—The Verdict**

In what civil rights leaders have called a landmark legal battle over affirmative action in higher education—the Bakke case of the 1980s, a former University of Kansas School of Medicine pathology professor, Dante G. Scarpelli, has won a libel suit against four former students and the former affirmative action officer. On November 17, 1979, a jury of nine white and three Black persons in Wyandotte County District Court found the four former students guilty of defamation of character. The court awarded $1,000 compensatory and $10,000 punitive damages from each of the former students, after Scarpelli had sued each for $55,000. Chester J. Rempson, the former affirmative action officer, was served with a $55,000 default notice.

The four former students filed a complaint against Scarpelli, claiming that he had tried to force them out of school, violating their civil rights. The faculty hearing called by Rempson ended when Dr. Scarpelli arrived attended by the school’s attorney and the students left in protest. A year later Scarpelli brought suit for a total of $1.4 million for libel and invasion of privacy.

Although Scarpelli claims that he was “practically being run out of Kansas,” he currently holds the pathology department chair at Northwestern, after turning down a position at Harvard during the proceedings. Although not identifying faculty individually, a HEW study in 1975 found that there was probable cause to conclude that the University of Kansas School of Medicine had discriminated against the four students sued.

James Meyerson, NAACP assistant general counsel and representative of the four students’ defense, said that the case will be appealed.

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The Cultural Crisis of Modern Medicine by John Ehrenreich.

John Ehrenreich has a well-earned reputation as a critic of the American health care system. He was a member of Health/PAC's own staff in the early 1970s and, together with Barbara Ehrenreich, co-authored the first Health/PAC book, The American Health Empire. If this most recent book—to which Barbara Ehrenreich also contributed ideas as well as essays—raises more questions than it can answer, it is because both Ehrenreichs have consistently undertaken the socio-political analysis of American health care at a refreshingly mature level.

Ehrenreich takes the title of this collection of essays on the uses and misuses of modern medicine from the theme he believes runs through the essays themselves. In a thought-provoking Introduction, he describes the development, over the past 10 to 15 years in the U.S., of a "cultural critique" of mainstream medical practice. Since the anthology ultimately hangs together around this theme of "cultural critique" or "cultural crisis," it is the issues raised in this Introduction that the bulk of the following discussion will address.

The cultural critique of medicine, the Introduction argues, consists of a direct challenge to the notion that "Western-style medical care is effective, humane and desirable."

This latter notion, Ehrenreich argues, has been held in common by both radical and liberal critics of the organization and delivery of U.S. health services for some time (with what he implies are minor differences between the liberals and radicals). Its most simple expression might be characterized as "more is better." Problems in the health system, from this perspective, are viewed as emanating from "the organization of medical care, and not as intrinsic to the nature of medicine itself." When employed by radical critics, Ehrenreich labels this approach the "political economic critique." and much of the balance of the Introduction is spent distinguishing the "cultural" from the "political economic" critiques.

The implication, although never quite formulated this way, is that the cultural critique followed the political economic critique historically—just as the 1960s and 1970s followed the 1940s and 1950s, the New Left followed the Old Left, and so on. Specifically, the roots of the seemingly newer cultural critique are traced in four relatively recent protest movements:

- **Anti-psychiatry:** The first of these is the challenge to the therapeutic benefits of psychiatry that arose during the 1960s. Here Ehrenreich's argument is a little fuzzy; it is never clear why attacks on psychiatry—some of which complained precisely that psychiatry was too unlike medicine in its lack of rigor and scientific basis—should have produced similar attacks on medicine. Of course the late 1960s abounded with movements and protests that targeted professionals and professionalism for their conservatism, racism, class basis and a host of other faults. How these specifically linked to a cultural critique of medicine is, however, not clear.
- **Revolts in Urban Communities:** A second wellspring for the cultural critique is identified in the Black, Hispanic and Asian community protests during the 1960s. When directed at the health system, these movements often targeted the racism and social control dimensions of a medical care practiced almost universally by white professionals. Although I think the argument is on target in linking this to broader liberation movements within and without the U.S., again the issue begins to cloud.

The implication is that in attacking the social and professional medium through which medicine passed, these attacks were actually addressing the scientific content of clinical medicine. Without nit-picking, it seems to me this confuses the issue, a theme I will pick up below. It is one thing to try to destroy the mystification of medical knowledge, the monopolization of skills, the racism and class biases of its practitioners. It is another to argue that, for example, penicillin is potentially dangerous or low-dosage radiation is probably carcinogenic. It is still another to argue that most of western clinical medicine is unable to treat the whole person, family or community and is unable to identify systematically the social, environmental and occupational
causes of disease that would allow many to be prevented. These latter issues involve the efficacy of the health care system as well as its underlying methodology in approaching disease and death. Unfortunately, despite some invoking of Illich and McKeown in the Introduction, the essays selected really do not touch on the questions of efficacy, causation of disease or modern medicine’s "scientific method."

The most widely acknowledged problem facing modern medicine is that costs are soaring ahead of effects . . .

Although the community protest movements of the 1960s can, I think, be credited with "discovering" some diseases—e.g., lead poisoning and Sickle Cell anemia—they did so using a kind of populist epidemiology that, in more formal hands, had been around as method for a long time. Equally important, these "discoveries" most often led to demands for more "Western style" medical care, while simultaneously attacking the practitioners of that care for their racism, class bias, professionalism and their failure to respond with appropriate services. In other words, there was less separation in practice of the "cultural" attack on medicine from the "political economic" attack than is implied. (Although I do remember that some of what Ehrenreich calls "cultural" questions, when raised in left circles in the late 60s–early 70s, were usually dismissed as being theoretically irrelevant. So it was with early attempts to deal with either the epidemiologic perspective, or with the notion of health as a developmental process requiring activism by those who seek it. The latter question has since largely been appropriated by the "holistic" health movement.)

The attack on professionalism: An explicit attack on the mystification, the monopolization of skills and knowledge, and the social and ideological infrastructure associated with professional dominance of medicine is cited as a third root for the "cultural critique." The social forces that embodied attack are identified as the women’s movement and the rise in both numbers and organized strength of nonprofessional health workers. Here I think the argument finds solid ground.

Each of these movements—in their own ways and for their own reasons—represented thousands of people who could not accept the male physician as arbiter of truth, wielder of hierarchical authority, and monopolist of benefit and privilege associated with human healing. Of the two, however, I think it must be said that is has been only the women’s movement that fits the niche Ehrenreich attempts to carve in history for the "cultural critique."

Confronted by an incredible history of inaccurate and damaging diagnosis and medical [mal] practice on women as patients, the women’s health movement has emerged as a discrete and articulate challenge to the content of traditional women’s medicine (principally Ob/Gyn) as well as its form. (This distinction between content and form is mine, not the book’s. Although the book implies the two are inseparable—and at one level of analysis they certainly are—I think it necessary to distinguish them for purposes of this discussion.)

. . . all the while there is a deterioration in many of the elements of quality care

In challenging the content of medicine, the women’s health movement has found more in common, it seems to me, with the broader self-help movement and the otherwise quite distinct and older public health movement in their common questioning of the basic methodology with which clinical medicine approaches human disease and suffering.

The attack on medical efficacy: The final source of the "cultural critique" Ehrenreich cites is the by-now-familiar subject of much of the current literature in medical sociology, social epidemiology, medical economics and medical care organization, namely the diminishing returns from geometrically increasing investments in traditional medical care. Although I would suspect any reader who has made it this far is familiar with the basic arguments, they can be briefly summarized. Despite rapidly soaring costs of care in recent decades, and despite evidence that this is not simply
price-gouging, but actually reflects more procedures being done on more people every day, keen observers such as McKeown and Illich have pointed out that there has been no commensurate rise in health levels in the U.S. population. Indeed, whatever quantum leaps have occurred in general health status can be shown to have arisen primarily from environmental changes rather than medical intervention.

In a brief discourse, Ehrenreich targets two characteristics of modern clinical medicine as responsible for its poor track record: (1) The single-cause approach to disease; and (2) the machine model of the human body. Unfortunately, on these promising notes, the subject is effectively dropped.

Finally, in a concluding discussion, the Introduction examines the potential for resolution of the "political economic" and the "cultural" attacks on medicine. Like a Greek tragedy, however, just as the drama peaks, we are thrown back into reality. In this case, the deus ex machina that terminates the plot is a call for a new "mass movement," (presumably as in the 1960s), that will synthesize the two critiques in practice.

While the latter may prove historically accurate, it hardly seems helpful for anyone engaged at any level of struggle with the current health system. Although invoking the vision of a socialist medicine that will be different, it provides the slimmest of clues as to what and how human health can be approached differently in a socialist society from a capitalist one.

However, Ehrenreich does make some of his best points on the way by. Socialist medicine, he notes, will not be, to use Robb Burlage's apt description, "Zero death, zero pain, zero suffering." Neither, Ehrenreich suggests, is it likely to throw away the baby of clinical medicine with the bathwater of its excesses. Finally, in perhaps the most provocative note, he points out that a socialist medicine is one that will accept and provide humanely for the reality of periodic human dependency without exploiting the vulnerability of the recipient in the process.

After all this, I think the reader is left up in the air. Now, of course, any review can be accused of discussing the book that might have been written rather than the one that was. But I think Ehrenreich invites a broader set of questions by implying the political synthesis of the various protests against medical practice will spontaneously flow from the rise of a new "mass movement." The latter is not only not described, but more important, the contribution that some of the newer anti-medical forces may make to such a movement are apparently not taken into account.

The problem with the concept of "cultural crisis," it seems to me, is precisely that it is far less than a whole crisis. And the problem with Ehrenreich's argument—as far as it goes—is that it over-uses the concept of "culture" (as does much of modern social science). The result is that when all is said and done, it isn't clear what has been explained.

If a "cultural" critique of medicine is a residual concept that includes any and all attacks on medicine—whether of its content, its method, its findings, its technology, or whatever—then such a critique is quite old. The poor, various ethnic minorities, women, rural migrants and various other subjugated and alienated groups have long sought alternatives to established medicine for resolving aches, pains and more serious ailments. Moreover, these alternative sources of caring and healing have generally come to co-exist quite peacefully.
this phenomenon head-on: "Medicine and Social Control" by the Ehrenreics themselves and "Medicine as an Institution of Social Control," by Irving K. Zola. Both are excellent examples of the literature on the uses of professional credentials and specialized knowledge for purposes of personal and social dominance.

The social control potential of medicine is further illuminated in the case of women's medicine in a set of five essays that make up Part 2 under the heading "Medicine and Women: A Case Study in Social Control." Contributors include Barbara Ehrenreich and Deirdre English, Linda Gordon, Doris Haire, Mary C. Howell, Diana Scully and Pauline Bart.

In a final section—"Part 3: Medicine and Imperialism: Of You the Story Is Told,"—the historic and contemporary potential of medicine for inter-cultural dominance is made clear in four essays that include Frantz Fanon's unparalleled "Medicine and Colonialism," as well as excellent pieces by E. Richard Brown, James A. Paul and Howard Levy. The common theme in this section is that of cultural imperialism and the unique contribution of medicine to the subjugation of whole nations and peoples.

Few serious students of medical care and its organization will quarrel with the common observation running through these analyses—i.e., that medical knowledge and practice are unique weapons in the hands of any person, sex, race, class or nation bent on dominance. And few radicals will question the generalization that such motivations and such dominance have heavily influenced the way medical care has been delivered through much of human history.

The interesting problem, however, is where do things go from there? The concept of a crisis arising within modern medicine due to its cultural alienation from its would-be beneficiaries (i.e., "health care consumers") requires, it seems to me, evidence that is simply missing here. Only in the case of women's medicine can one see how such a crisis might occur: cultural alienation from male Ob/Gyn practitioners led first to challenging the manner of clinical practice, then to the actual biomedical knowledge (supposedly) underlying that practice, and finally to directly challenging the method whereby such findings were derived. That is a critique, all right, and it presents real crisis as well. The reader would have no trouble with the thrust of the argument, I suspect, were this book entitled, "The Modern Crisis in Women's Medicine."

What is striking about all of the other forces Ehrenreich identifies as contributing to the "cultural critique," however, is that none of them ever really challenged the body of knowledge, much less the methods of the bio-medical sciences that are at the core of clinical medicine.
Ironically, meanwhile, modern medicine as a whole is in crisis—or at least beset by a number of deepening contradictions and under attack from several quarters.

The most widely acknowledged problem facing it, of course, is that its costs are soaring, far ahead of its effects. The health costs situation has been explored in too many other quarters to fully restate here, but two major points about escalating health costs need to be firmly grasped: (1) The major underlying dynamic in health costs inflation is the phenomenon economists call intensification. One way to understand intensification is to note that a number of sophisticated analyses have shown that the basic variable in rising hospital rates (the "heart" of the costs spiral) is that more and more "procedures" are being done to the average patient. This involves more physical commodities (e.g., drugs, eyeglasses, and prosthetic devices, not to mention amenities such as telephones, TV's and exotic menus for inpatients) as well as commoditized services (e.g., fragmented subspecialty therapeutic procedures and computerized diagnostic tests). Both are delivered in increasing numbers every year to the same patient for the same condition. (2) The causes of illness are probably increasing at a rate faster than the growth of the population, so that any medical system would be strained to keep up with them.

Much intensification derives from "defensive medicine" on the part of physicians—i.e., the ethic of "First Don't Forget Anything That Might Produce a Malpractice Suit." It is also fundamentally tied up with the continuing, immense marketing effort of the hospitals industry and its suppliers—e.g., the drug industry, the hospital supply industry, the hospital construction and medical computer industries.

The "bottom line" of the intensification process is literally that "more is better." Generally the "more," however, is largely illusory—i.e., more procedures, more tests, more drugs, perhaps more visits with the provider—but little or no improvement in outcome, or at least in measurable outcome. (There is probably an actual deterioration in many of the elements of quality care, meanwhile, with increased waiting times, record coordination problems, and harmful side-effects of newer and newer procedures "rushed" to the patient.)

The impact of all this on health levels in the population is often neutral at best, negative at worst. As medicine gets more expensive, more and more of those who pay for it—notably government, business and organized labor—want to know why. Although there is no consensus on the explanation yet, it is at least worth noting that Congress itself has recently funded a major study critical of medical technology, that medical technology is increasingly scrutinized and regulated, and that even the American Surgical Association (!) recently called for programs whereby the general public "should be made aware of the limitations as well as the triumphs of modern medicine."

All these developments, of course, speak to a sobering reality for health activists: the cost crisis—and the related crisis of medical efficacy—are by and large "their" problems, not "ours." That is, consumers, urban minorities, women's groups, and "health leftists" are generally far more concerned with access (more) and control (how) than with the content (what) of health care. As a result, those who might seize the cost-efficacy crisis in order to challenge the distorted priorities of American medicine—to demand more prevention, more primary care, more community-based services that deal with the social and environmental roots of illness—are, instead, often as mystified as the average citizen by the claims of the providers.

Lacking the artillery to attack the content of medical care, consumers and community activists have simply proven no match for the providers. Lacking an articulated vision of humane health care that is a real alternative to TV's "Medical Center," we are often reduced to demanding a Medical Center in every community and a token voice in running it. As a result, costs and efficacy remain issues that trouble only the institutional payors and their constituents (the latter including taxpayers' groups, health benefits analysts, health policymakers and medical providers themselves—generally a conservative lot).

To counter such a dismal situation, one can hope for a real movement that would seriously try to define a progressive content for health care and the broader public health. One might also hope that this movement would recognize its natural affinity with those whose principal targets are the environmental, occupational and social causes of illness—i.e., the environmentalists, the health and safety labor groups, and those fighting housing, nutritional, educational and economic injustices.

Such a broad movement would place high on its agenda two priorities currently noticeable for their absence: (1) an epidemiologic or public health orientation to health care delivery—i.e., one that concentrates most resources in areas of most need and puts the major emphasis on prevention rather than late-stage curative techniques; (2) an em-
phasis on developing healthy communities, workplaces and social relations as indispensable to humane health care.

If such a movement remains an illusory hope at present, it is nevertheless likely that nothing short of it will ultimately be required to successfully challenge the hegemony of high-technology, high-specialty, high-cost medicine. That is, the problem Ehrenreich raises is bigger than either the "political economic" or "cultural" critiques, or even some convergence of the two, can resolve. If there is a spectre haunting modern medicine, its nature is probably best suggested by the one contribution to this book that does not see the problem as only the misuse of medicine for purposes of social control. In an essay entitled "On the Structural Constraints to State Intervention in Health" originally published in 1975, Marc Renaud suggests the basic question is that of "The implementation of an altogether different approach to health, disease, and medicine... The decommodification of health needs, leading to a more intense and direct preoccupation with the social conditions giving rise to disease. Specifically, it involves the development of a new medical knowledge based on what has been called an 'ecological' approach, the elimination of private property in skills, training, and credentials, and a reversal in the actual trends in the allocation of resources toward therapy and prevention, so that human beings can self-produce care of their bodies and minds, individually and socially."

If no such well-defined alternative to modern medicine currently exists, there have at least been some attempts to move this broader agenda along during the 1970s. One might end by expressing the wish that this volume had included some of these efforts—whether from the Marxist epidemiologists, the holistic health practitioners, the self-help writers or the Illich-McKeown strain of medical nihilists. For it is increasingly difficult to believe, as we enter the 1980s, that the crisis Ehrenreich and most radical observers devoutly wish on modern medicine can continue to safely ignore its very content. Ultimately this is a tall order, of course, since Ehrenreich is certainly right when he notes that "To ask what kind of medical care we want is... to ask some very basic questions about the kind of society we want to live in."

—Michael E. Clark
Peer Review

No Naivete, Please

Dear Health/PAC Bulletin:

The medical care system seems to be moving remorselessly on to higher inflation, more technology, less personal care and less attention to the needs of the poor, the infirm, the aged and the minorities. Clear advice and guidance toward change in the medical care system where possible is needed; where the system itself must be changed to produce such improvement must also be broadcast. Unhappily, the people’s champions seem unable to move beyond polemical attacks and vague catchwords for proposals.

Cynthia Driver’s essay on Home Health Care in the Triple Issue is a case in point. Driver is certainly knowledgeable about the frightening inadequacies of long-term care for the old, sick and poor; decently indignant about the abuses and neglect. But her audience deserves more than the simplistic and therefore misleading discriptions and discussion she offers.

“Community” although apparently defined, is unclear. Where is the political mandate? Where will the money come from and to whom will it be given? Who will be accountable? How will the professionals get integrated into the “currently fragmented and discontinuous pattern of services”?

Parenthetically, why are we subjected to the naive “all or none law” in regard to hospitals? Are they all bad, untrustworthy, mean, selfish, means imperial? Can there exist a hospital that serves a community purpose, even a non-public one? I was responsible for the operation of the Montefiore Home Care Program from 1951-1965. We were losing money for the hospital and for the Federation of Jewish Philanthropies at a great rate. But we thought we were demonstrating that people should best be accommodated in a place suited to their needs, not warehoused in institutions. We wanted them out of hospital and out of nursing homes for their sakes, not ours, or the financial benefit of the institution. We had recreational, occupational, physical therapists, social workers, “friendly visitors”; put in telephones at our expense to allay the insecurity and fears of the patients and their families; readmitted patients to the hospital as needed, bypassing the usual admission office because they continued to be hospital patients (yes, continued to be hospital patients outside the walls). Was that bad?

Before Medicare’s rigid regulations, we were also able to admit patients for social reasons: to allow the family to have a vacation in the summer, or go to a Bar Mitvzvah in Philadelphia over a week-end.

The reason less money has to be appropriated for Home Care, even the deluxe type described here, is because the hospital overhead doesn’t have to be paid. True, there is an overhead at home, and we worked that out with the Welfare Department, so that two agencies were paying for the home service, but the medical care costs—doctor’s visits, nursing and the whole host of other medically related services, oxygen, medications, wheelchairs, and the rest—came out of the Home Care budget. Food, rent, clothing came out of Welfare.

Was that bad? We had a salaried service, careful record keeping, supervision from a medical director, weekly conferences, access to specialists as required, transportation. We knew that 20% of patients in hospital didn’t need to be there; that maybe 75% of nursing home patients didn’t need to be in those institutions. Wasn’t it a socially necessary and desirable activity? Wouldn’t as much money be saved to be used for other useful purposes if a similar type of community home care were introduced in New York, America? Isn’t this the long sought “alternative to institutional care”?

I also resent the equating of “home health services” with Home Care. Sure Medicaid and Medicare compel the kind of fragmentation and wasteful and impersonal kind of non-institutional services that Driver decries. But a comprehensive report should have distinguished between Upjohn and Montefiore; as a matter of fact, should have elaborated...
much more on the possibilities of what Montefiore's Home Care offered and what it could do for New York and the country.

In short, the Health/PAC Bulletin owes its readers a more dispassionate, thoughtful and objective, comprehensive analysis of Home Care than we got. I have the impression that the same could be said about many other articles, about which I may not have the personal background and information that I do about Home Care. This is not only unfair, it is stupid. There are so few journals or locations altogether where one can get a non-establishment point of view and factual background that it is doubly sad that all one can get on a critical medical care issue like Home Care is another polemic.

Let's try to avoid classification by role (all doctors, etc.) or social position (all hospitals, etc.). Let's adopt an even-handed, temperate approach to criticism—one can criticize one's friends without attacking them along with the enemy—avoiding political compromises and keeping an eye on the main goal, which is better medical care for all the people.

Sincerely,

George A. Silver, MD,
Professor of Public Health,
Yale University School of Medicine

The author replies:

As we stated in the article, a comprehensive Home Care Program is a potentially progressive alternative to overly institutionalized, expensive, health care. Our intention in this article was to present a critical view of the current Home Care situation. Dr. Silver's interest in underlining the positive aspects of Home Care is legitimate and a positive contribution to the discussion of Home Care's role in the health care system.

—Cindy Driver

Training that Alienates

To the Editors:

Medical students start out with genuine, albeit vague, intentions to help others and to share in their lives. But the process of their education causes profound changes to take place, changes at the root of that many of their present malaise.

Very little in medical school is taught directly. Skills and attitudes are imitated until they conform to unwritten standards. Decision making depends on the limits of one's own conscience and on whom one suspects is looking. An oft-cited adage is, "see one, do one, teach one." Dogma gets passed along without room for questions. Students start out with moral and ethical principles of their own but the design of their education makes it difficult to exercise or test those beliefs.

Medical education is a lonely experience, though it seemingly brings one into contact with the most basic of human emotions and needs. The human side has been culled out in favor of the competition for exertion and scientific excellence. It is the rule of the iron man, embattled but unbowed, whites covered with excreta the morning after the big flog. If each must stand alone, no one tries to support the patients or their frightened families, caught in the white bustle and the latin jargon. If anyone attends to this it is the student, but it is a job done on one's own time, seen by teachers as a luxury and an escape from more serious work. Students are taught how to keep these patients at arm's length.

Students have a hard time rationalizing what they must do to other human beings. Literally they must practice painful and uncomfortable procedures. The hospital offers them help in the patients it selects for learning: on the "public" wards, at the veterans' hospital. No longer charity cases, most of these patients pay for the services they receive. But still "green screens" and "pocketbook biopsies" sort out Blacks, Hispanics, and poor whites and send them to the dingier waiting rooms, the turn-of-the-century open wards, the poorly supervised care of hurried learners. Students get the message that these people deserve less and can be tolerably hurt in return for the generosity they receive.

Most practitioners spend their time in an office or clinic, where the bread and butter of daily complaints are heard. Yet medical school goes out of its way to paint this activity in the most distasteful of lights. Outpatient ex-
periences are severely limited, looked at as second rate learning experiences and as institutional liabilities in the ledger book. Instead of presenting the intellectual and human rewards of ambulatory work, students are shown nightmares of poor organization and planning: days in a tumbledown rural health department dispensing birth control and Flagyl to mute women herded into cramped exam rooms, patients waiting for hours for the simplest of follow-up visits.

Worst is that the students come to dislike themselves for the things they start to do, the corners they begin to cut. Few really know why they are in medical school, and the railroad track of curriculum leaves little room for originality. The pace is fast as 36-hour days blend into weeks of five nights on call. The patient that takes extra time, whose language is difficult to understand, whose story is not simple, becomes a personal assault. White, middle class students find that white, middle class patients are articulate, quickly comprehensible, rewarding to care for. The poor, Black, and Hispanic patients are hard to talk to, get in the way of quick admission work-ups, and are unlikely to do what they are told.

With fatigue, the outside supports and relationships slip away. There is no chance to regain some of one's own humanity, to get some perspective on the incredible ethics of the hospital. As one's language and expertise get farther and farther from the "layman's" comprehension or interest, only other doctors can appreciate one's worth, and only patients who have read all about it in the Times can understand why they are asked to do such bizarre and painful things. A crop of little big men look for someone to blame for the sacrifices they have made without knowing what they were getting themselves into, for their status of lord on the hospital floor and the emptiness of their lives when they take off their name tag and white coat. Only the mobile middle class can appreciate these doctors for where they are going and ignore the dismal quality of where they are.

The poor or minority patient lives a separate reality, has concerns of a much more fundamental nature than the new doctor is capable of addressing. Not only has the new doctor had little training in nutrition, economics, or the politics of discrimination, but the process of medical education has stripped away the human roots that might enable her or him to come to grips with these problems in others. Students need time and help to come to grips with social and personal issues. Until they do, their training will only further alienate them from the people they are starting out to serve.

Sincerely,
Larry Wiswos, M.D.

(Larry Wiswos is an intern at Johns Hopkins)
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Wholistic Health
A WHOLE-PERSON APPROACH TO PRIMARY HEALTH CARE

Tubesing, Donald A., Ph.D.
WHOLISTIC HEALTH
A Whole-Person Approach to Primary Health Care

This pioneering work is an eloquent call for a redefinition of health and illness in the context of a broader view of life, health, and the quality of life to include the whole person: the mental, emotional, and spiritual sides of life as well as the physical. It is based on the premise that only a redefinition of health care to include the whole person will lead toward solutions to the problem of the present health care system.

Dr. Tubesing, the author of this thoughtful presentation, states emphatically that there is much we can do in moving toward positive, workable solutions to many of the problems in contemporary health care. One solution is the Wholistic Health Center project, in which Dr. Tubesing has played a central role from its inception.

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