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Inequities in access to health care and in health status have existed on this continent since the arrival of enslaved Africans to the Virginia Colony in 1619. The physicians in the English colonies during that time received their training in Europe or had learned their skills by apprenticeship to other physicians.

The first hospital in the English colonies was organized in Philadelphia in 1751, by Dr. Thomas Bond and Benjamin Franklin, followed by the first medical school at the University of Philadelphia in 1765. The next medical schools were developed at Columbia University in 1768 and Harvard University in 1783. During this period, the practice of medicine in the colonies was largely unregulated. Many medical practitioners learned their skills by apprenticeship to other physicians rather than receiving formal education at medical schools.

Healthcare for slaves was often provided by other Blacks who were self-taught practitioners, root doctors or midwives.

In 1847 David James Peck graduated from Rush medical College in Chicago, the first African American to graduate from a medical school in the United States. Two years later, in 1849 two more African Americans, John Van Sundy De Grasse and Thomas L. White, graduated from Bowdoin Medical School in Brunswick Maine.

Other Blacks admitted to a medical school in America were Martin Delany, Daniel Lang and Issac Snowden at Harvard in 1850. Because of resistance from their fellow White students Lang, Delany and Snowden were expelled in 1851.

In 1863 Dr John De Grasse became the first black medical officer in the United States Army, serving with his regiment in South Carolina during the Civil War. In 1864 Rebecca Lee Crumpler became the first black female physician in the United States when she graduated from the New England Female Medical College (now Boston University). One hundred years after the first medical school had been organized in the colonies, the first medical school formed to train Black physicians was developed at Howard University in Washington, D.C. by the

Freedmen's Bureau in 1868. This was followed by the founding of Meharry Medical College in Nashville Tennessee in 1876.

Six additional medical schools for Blacks opened during the remaining years of the 19th century in Louisville (KY), Raleigh (NC), Memphis (TN), Chattanooga (TN), Lincoln (PA), and New Orleans (LA).

Because of legally-enforced segregation and discrimination, at the beginning of the twentieth century none of the medical schools in the southern states admitted black students. Medical schools in the rest of the country (New England, the Midwest, the mid-Atlantic states) had relatively few black students.

In 1900 the health status of black Americans was clearly poorer than that of White Americans, (shorter life expectancy, higher infant mortality, etc). **SLIDE #1**

Because of concerns about the quality of medical education in America, the Carnegie Foundation commissioned a study of the 148 medical schools which existed in the United States and Canada. This evaluation was conducted by Dr. Abraham Flexner from 1908-1910, during which time he visited all of the existing medical schools. His report, Medical Education in the United States and Canada, had a major impact on medical schools and medical education. He found a number of the schools lacking in sufficient faculty, in facilities, in curriculum and

in educational standards. He proposed that a number of the schools be closed because of their deficiencies. As a result, a number of schools did close over the following years because of a lack of financial support, a decrease in enrollment of students, or other factors.

Flexner found the academic enterprise at Howard and at Meharry to be satisfactory. He cited the need for Black physicians, to address the health needs of the Black community, to reduce the incidence of tuberculosis and other diseases in the Black Community and to decrease the risk of transmitting infectious diseases to the White Community.

Flexner recommended that the six other Black Medical schools be closed because of their deficiencies. By 1925, the number of all medical schools in North America had decreased to 80.

By 1950, the 80 medical schools in the United States were graduating some 8000 physicians annually, of which approximately 200 were African American. Almost all of these 200 were graduates of Howard or Meharry. In 1950, African Americans were 10 percent of the U.S. population but only 2 percent of the nation's physicians.

The first African American admitted to a medical school in the segregated Southern United States was Edith Irby, at the University of Arkansas School of Medicine in 1948. This was six years before the U.S. Supreme Court ruled, in 1954, “separate but equal” educational systems were not truly equal and, thus, were unconstitutional.

In May 1954, I graduated from Morehouse College in Atlanta and enrolled as a first-year student at Boston University School of Medicine. I was the only Black student in a class of 76. Because of legally enforced segregation in Georgia at that time, I could not attend a medical school in my home state. It was not until 1963, almost a decade after the Supreme Court decision in Brown vs Board of Education that Hamilton Holmes was admitted to Emory University School of Medicine, becoming the first African American admitted to a medical school in Georgia.

In 1960, the medical schools in the South comprised one third of all U.S. medical schools. They slowly complied with the Supreme Court’s decision, Vanderbilt and Duke being the last to do so, admitting Levi Watkins (Vanderbilt) and Delano Meriwether (Duke). During his career Watkins became professor of cardiothoracic surgery at Johns Hopkins Medical School and was a leader in

Cardiovascular surgery. In 1976 Meriwether led the U.S. government's immunization program against the service outbreak and won the Olympic 100 yard dash in 1971.

Meanwhile, expansion of medical education in the United States had begun in 1956, with the opening of two new medical schools-Seton Hall School of Medicine in Jersey City, New Jersey and Albert Einstein School of Medicine in the Bronx, New York. These were the first of 47 new medical schools to open between 1956 and 1981 in response to two reports issued in 1955 and 1957 which projected a shortage of physicians in the United States if medical education was not expanded. In addition to the 47 new medical schools, funded with federal, state and philanthropic funds, federal funds were also provided to the 80 existing medical schools as incentives for them to increase their class sizes, to help avert the predicted physician shortage. The 47 new schools and the expansion in class size of the existing 80 schools resulted in a doubling of the number of physicians trained in the United States. By 1981 there were more than 16,000 medical students admitted annually to the 127 medical schools which existed at that time.

Other societal events were changing the complexion of the health system. The Civil Rights Movement (1955-1970) led by Dr. Martin Luther King, Jr. and others, led to a dismantling of segregated institutions and some of the other forms of disenfranchisement. The Great Society legislation of President Lyndon Johnson and the U.S. Congress in the mid 1960's resulted in the enactment of Medicare and Medicaid health insurance, the desegregation of hospitals, and their physician staffs, fair housing legislation, fair labor laws. There was the creation of a new cabinet agency, the U.S. Department of Housing and Urban Development, led by Robert Weaver, the first Black Cabinet Secretary in U.S. history. Head Start and other childhood development programs were initiated.

With the enactment of Medicare and Medicaid legislation, the expansion of health professions educational programs, and the Civil Rights revolution of the 1960's and 1970's, there was increased interest in the racial, ethnic and gender diversity of the nation's healthcare work force. Following the shocking assassination of Martin Luther King, Jr., in April 1968, colleges and universities around the country responded with a series of actions including self-assessments of their level of diversity and opportunities for minority students and faculty. These assessments were also made by medical schools and educational associations such as the Association of American Medical Colleges. (AAMC)

One example was an initiative organized by medical schools in New England. In 1968 I was Associate Professor of Medicine at Boston University School of Medicine, my medical school alma mater. I had graduated in 1958, the only African American in my class of 76 graduates and one of only three Black students in the entire medical school at that time. I noted that in 1968, there were seven African American medical students at Boston University, a modest increase after ten years. With about a dozen of my faculty colleagues at Boston University (black and white) we decided that this was not acceptable, and we should do something about it. Medical faculty at Harvard and Tufts University had similar observations and thoughts. So, medical faculty from Boston University, Tufts and Harvard all came together and organized a recruitment effort over Thanksgiving weekend, November, 1968. We raised funds locally and invited pre-medical students from 24 black colleges in the South, to Boston. We were joined by faculty from other medical schools in New England, including Brown, Dartmouth. The University of Vermont and the University of Massachusetts. Our message to the pre-medical students was an invitation for them to apply to our schools: that we wanted them, we welcomed them and their classmates; that medicine was a noble profession of service and a dynamic,

exciting scientific field of constant growth and discovery, that they should be a part of.

As a result, the following fall, in 1969, all of the medical schools who had participated in the 1968 Thanksgiving weekend program experienced significant increases in the enrollment of Black students – except for Vermont. Led by Dr. Larry M. Corey, Vermont had tried valiantly to recruit the students, but it appeared that the students' concerns about winters in Vermont weighed heavily on their decisions.

The number of African Americans entering U.S. medical schools annually increased from approximately 200 ± in the 1950's to approximately 800 by the 1980's associated with a number of programs: individual recruitment initiatives of medical schools, various forms of student financial aid from federal sources such as the National Health Service Corps Program, the Exceptional Financial Need program; and others.

In the mid 1960's the Charles R. Drew Postgraduate Medical School and the Martin Luther King, Jr Hospital were founded in Los Angeles to provide postgraduate residency training programs for Black physicians, and health care for residents in the Compton section of Los Angeles, , in response to the Watts riots.

And in 1975, Morehouse College founded the Morehouse School of Medicine, the only predominantly African American M.D. degree granting four-year medical school which was created in the United States in the 20th century. In addition to increasing the number of Black and other minority physicians, Morehouse School of Medicine's mission is to increase the number of primary care physicians for medically underserved rural and urban communities. Alumni of this 45 year old institution have served as president of Meharry Medical College, president of SUNY Downstate Health Sciences University in Brooklyn, Surgeon General of the U.S. Public Health Service, Commissioner of Public Health for the State of Georgia and Developer of the National Blood-Banking System in South Africa, modelled after the American Red Cross Blood Service. MSM was cited as number one in social mission among all U.S. medical schools in a survey published in 2011 in the Annals of Internal Medicine, the official publication of the American College of Physicians.

In 1981, Charles R. Drew began a two year undergraduate medical program in collaboration with UCLA School of Medicine. Drew is currently exploring the possibility of developing a four-year undergraduate medical program leading to the M.D. degree.

Since the year 2000, we have seen the development of some 25 more medical schools to address the needs of the growing U.S. population. The doubling in the class size of entering U.S. medical students, from 8,000 in the 1950's to 17,000 in 2014 was accompanied by an increase in the average number of entering Black students from 200 in 1950 to 1227 in 2014.

In the Fall of 2019, there were 1626 Blacks among an entering class of 21,863 first year medical students. In summary, since 1950, the class size of first year U.S. medical students has increased from 8,000 annually to almost 22,000 to meet the needs of a growing nation's population. The number of Black students entering U.S. medical schools has increased from 200± (2.5%) to 1626 (7.4% of medical students). During this period the Black population in the United States increased from 10% to 13.0%.

The efforts over the past 5-6 decades, to increase the representation of Blacks in the nation's physician workforce have resulted in a modest increase, from 2% in 1950 to 5% today. The percentage of Black medical faculty at U.S. medical schools is less than 5%.

All of these data show the need to increase our success rates in training more Black physicians.

Why is this an important goal?

In 1996, Dr. Miriam Komorany and her colleagues at the University of California San Francisco Medical Center reported that Black and Hispanic physicians were three to five times more likely to establish their offices in the ghetto or the barrio. They also noted that these physicians' practices were different. They had a higher percentage of patients on Medicaid or with no health insurance.

In the early years of the twenty-first century, several reports emphasized the rationale of continued efforts to have a racially and ethnically diversified health professions workforce. The publication "Unequal Treatment", issued by the Institute of Medicine in 2003, edited by Brian Smedley, described the problem of bias in the health care system-conscious and unconscious bias among health professionals. This bias often resulted in African Americans receiving less than optimal treatment (1) for pain relief, (2) for cardiac catheterization, (3) vascular grafts for lower limb vascular disease and (4) other health care issues. **SLIDE #2**

And in 2004, the report from the Sullivan Commission, "Missing Persons", documented the on-going shortage of Blacks, Latinos and Native Americans in medicine. The Sullivan Commission held hearings around the country in 2003-

2004, to explore why the efforts to increase diversity in the nation's physician workforce had not been more successful. **SLIDE #3** Among the factors identified were (1) the poorer quality of the educational programs for Black students and other minority students in the K-12 educational system; (b) lack of minority role models for the students among the health professions; (c) absence of mentoring or career counselling; (d) the need for a strong and clear commitment to diversity from the leadership of the institutions (or programs); (e) the requirement for adequate student financial aid; (f) a supportive, collaborative learning environment. These findings were reinforced by a report from the Institute of Medicine in 2004, "In the Nation's Compelling Interest", the work of an IOM Committee chaired by Dr. Lonnie Bristow, the first African American president of the American Medical Association. These reports led to the development of the Sullivan Alliance, which for a number of years, was based at the joint Center for Political Studies, in D.C., its membership included former members of the Sullivan Commission and the IOM Committee for "In the Nation's Compelling Interest".

The purpose of the Sullivan Alliance has been to stimulate the development of programs linking undergraduate colleges which have significant numbers of

African American and other minority students with medical schools and academic health centers to broaden the pipeline of students for careers in the health professions. Alliance programs have been developed and sponsored in Virginia, Ohio, Florida, North Carolina and Nebraska. They have included summer research projects, lectures, seminars, counselling, and MCAT preparation. Membership in the state alliances has included schools of medicine, nursing, public health, pharmacy, allied health, state health professions associations, and non-profit health insurance companies. Successful state alliances have all had strong, committed state leadership.

A number of alumni of the program are now physicians, nurses, physical therapists or other health professionals.

But we also have evidence of bias in the selection process for investigation-initiated research grant awards from NIH to first time applicants. **SLIDE #4** In the study by D.K. Ginther and colleagues, published in science in August, 2011 Black applicants experienced a success rate of 16% whereas 29% of White applicants. The investigators controlled for years of education, degrees awarded, and other variables.

Because of the on-going need for programs to broaden the student pipeline of African Americans, Hispanic American, Native American and other minorities in the health professions, we are particularly pleased to have joined with the Association of Academic Health Centers, under the leadership of President Steven Kanter. The Advisory Committee of the Sullivan Alliance includes:

1. Dr. Jay Gershen, former president of Northeast Ohio Medical University
2. Dr Greer Glazer, Dean of the College of Nursing University of Cincinnati
3. Dr. Wayne Riley, President and CEO, SUNY Downstate Health Sciences University
4. Dr. Jeanne Sinkford, former Dean, Howard University College of Dentistry
5. Mark Nivet, Executive Vice President Institutional Advancement, The University of Texas Southwestern Medical Center
6. Dr. Ricardo Martinez, Chief Medical Officer, North Highland
7. Dr. Valerie Williams, Chief Academic Officer, AAHC

SLIDE #5, #6, #7

To enhance and extend our initiatives around the country, we have been exploring opportunities with the Links, a 74-year-old national organization of

16,000 African American women with a strong commitment to community leadership and service. We are encouraged by their interest and we are excited about this possibility.

Working with the AAHC and its members we look forward to enhancing and expanding our approaches to increase diversity in the nation's entire health workforce-in clinical practice, in research, teaching, health administration and health policy.

The COVID-19 pandemic has brought new attention and greater focus on the striking disparities in access to health care and in health status between whites and the nation's minority populations, disparities which still exist in our nation in 2020. Working with the AAHC and its member institutions we are committed to the reduction and the eventual resolution of these disparities. It will require sustained efforts over the years and unwavering commitment. But, with our new partnership I am confident that we will succeed.

Thank you-