

NARRATIVE MATTERS



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Grasping At The Moon: Enhancing Access To Careers In The Health Professions

A former HHS secretary reflects on what's needed to enable more minorities to become doctors and other health professionals.

BY LOUIS W. SULLIVAN

When I was a child in our small town of Blakely, Georgia, the seat of Early County, there were only two doctors. Both were white, with separate waiting rooms for their white and black patients. For blacks, this usually meant going around to the back of the building to enter the blacks-only waiting room.

Growing up in rural southwest Geor-

gia in the 1930s, during the Great Depression, I witnessed poverty, poor health, and deprivation firsthand in our community. We lived under a social structure of legally enforced brutal segregation. Blacks could not vote or otherwise participate in government. For employment, they were relegated to lower-paying positions, if they were fortunate enough to have a job at all.

Most black farmers were not land-

owners; they worked as sharecroppers on land owned by whites. During the planting, tilling, and harvesting of the crops, the white owner provided the funds for seeds, fertilizers, tractors, and other equipment. Labor was provided by the farmer. At the end of the season when the crops were sold, the white owner would be repaid first, and any funds left over would be divided between the tenant farmer and the white owner. For many black farmers, this worked to their extreme disadvantage.

There were no black doctors, dentists, lawyers, or engineers and few black-owned businesses in our community. Most black residents worked at white-owned businesses, on farms, or in white homes as domestic workers.

My father, Walter W. Sullivan Sr., had moved our family from Atlanta to Blakely in 1937, when I was almost four years old, and he established the first black funeral home in Early County. He also operated an ambulance service, where my older brother, Walter Jr., and I helped out. That's how, a year later, in Bainbridge, Georgia, forty-one miles south of Blakely, I met the only black physician in southwest Georgia at that time, Dr. Joseph Griffin. It was a life-changing experience for me.

Dr. Griffin had built a twenty-five-bed brick hospital and clinic—an unusual building in that part of the United States at that time, where most structures owned by blacks were made with wooden siding. He was highly admired in the community. He could cure those who were sick or injured, which seemed like magic to me. I already loved science and nature, and I decided that I wanted to be just like Dr. Griffin. I wanted to help people who needed a doctor. And, like Dr. Griffin's patients, my patients would be treated with the respect and dignity they deserved. Black patients would be addressed as “Mrs. Jones” or “Mr. Williams” instead of by their first names, as they were always addressed by white doctors and their staff.

My quest for equal treatment of patients regardless of race was instilled in me by my father. He had founded

the first chapter of the National Association for the Advancement of Colored People (NAACP) in Blakely in the 1930s and brought a lawsuit against the county and state governments because of Georgia's primary voting system, which did not permit blacks to participate. He initiated the annual Emancipation Day celebration in our town, held on January 1, with a parade downtown around the courthouse square and bands, speakers, picnics, and voter recruitment and education programs.

My mother, Lubirda, was a schoolteacher, but because of my father's political activism, she was never able to get a position as a teacher in our local school system during the twenty years my parents lived in Blakely. Instead, she traveled daily to teach in communities outside of Early County, between fourteen and forty miles away. My brother and I were enrolled in the schools where she taught, and we traveled with her.

At age five, after meeting Dr. Griffin, I told my parents that I wanted to become a doctor. "That's wonderful, Louis," they exclaimed. "You would be a great doctor." That was all the confirmation I needed. From that date on, there was never any doubt in my mind that I was going to provide needed medical services in my community, with dignity and respect for the patients.

In 1950 I enrolled at Morehouse College. Though my mother was an alumna of Clark College in Atlanta, and my brother had enrolled there a year earlier, I was impressed by the number of black doctors who were alumni of Morehouse, a predominantly black, all-male college.

From Medical School To HHS

At Morehouse College, my classmates and I came under the influence of the school's challenging educational and social environment and dedicated faculty and staff, led by the school's president, Dr. Benjamin E. Mays. He was a sophisticated, well-educated man of great integrity and impeccable conduct—a true role model. All of us wanted to be like Dr. Mays. In his eloquent weekly chapel addresses to the students, he challenged us to "reach for the stars and grasp at the moon." He said that each of us was born to make our own unique contribution to the world; our task was to find out what



that was and work to achieve it. We were also encouraged to work for the elimination of a segregated society and for the uplifting of ourselves and others.

Four months after graduating from Morehouse in May 1954, I entered Boston University School of Medicine. It was the year of the landmark *Brown v. Board of Education* decision by the US Supreme Court that declared segregation in schools to be unconstitutional. I was the only black in a class of seventy-six medical students.

My family had only modest resources, but I had no financial concerns about attending medical school. Scholarships were available to financially needy students like me, and medical school tuitions were not in the stratosphere where they are today, costing as much as \$60,000 per year. I worked at summer jobs to help cover the costs. The concept of having to borrow and incur massive debt to become a doctor did not exist during my medical school years. When I graduated, I had only \$500 in educational debt, which I paid off by the end of my internship year.

After postgraduate training in internal medicine and hematology at New York Hospital–Cornell Medical Center and at Thorndike Laboratory–Harvard Medical Unit at Boston City Hospital, I eventually became a professor of medicine at Boston University and chief of the Division of Hematology at Boston City Hospital.

In 1975, after living twenty-one years in the northeast, I moved back to Atlanta. Morehouse College had recruited me to be the founding dean of Morehouse School of Medicine, the only

predominantly black four-year medical school established in the United States in the twentieth century. After the medical school became independent from Morehouse College on July 1, 1981, I served as president of the medical school until January 20, 1989, when I was appointed by President George H.W. Bush to serve as health and human services secretary.

At that time the Department of Health and Human Services (HHS) had the fourth-largest annual budget in the world: \$600 billion, exceeded only by the government budgets of the United States, Japan, and the Soviet Union. (By contrast, the budget of the US Department of Defense was \$300 billion in 1989.) HHS had 125,000 employees and managed more than 250 programs, including Social Security, Medicare, Medicaid, the Food and Drug Administration, the National Institutes of Health (NIH), the Centers for Disease Control and Prevention, and many others.

During my tenure as secretary, from 1989 to 1993, HHS achieved much. We launched *Healthy People 2000* in September 1990, developed a new food label in 1991, and mounted strong programs to discourage cigarette smoking and other tobacco use. We also persuaded Congress to increase the annual research budget for NIH from \$8 billion to more than \$13 billion and increased gender and racial diversity among senior leaders at HHS. Our administration saw the appointment of Bernadine Healy, the first female director of the NIH; Antonia Novello, the first female and the first Hispanic surgeon general; Gwendolyn King, the first black female commissioner of the Social Security Administration; and William Toby, the first black administrator of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services). In 1993 I returned to Morehouse School of Medicine, serving as president until 2002.

As a result of the investment made in me through scholarships available in the 1950s, I was able to make some contributions to society that I otherwise could not have made. Other blacks in my generation could say the same. Mitchell Spellman, for instance, was founding president of Charles Drew School of Medicine in Los Angeles. Augustus

White developed the residency program in orthopedic surgery at the Boston Beth Israel Hospital. Asa Yancey was the first black physician to serve as chief medical officer at Grady Hospital, in Atlanta. And Claude Organ was the first black chair of surgery at a predominantly white school of medicine, Creighton University.

Today, graduating from medical school with a mere \$500 of debt seems unimaginable. With high tuitions for medical school and limited scholarship dollars, it is now common for a medical student to accumulate debts of \$150,000 to \$250,000 by the time he or she graduates—and some owe even more.

Because of this reality, many college students, especially minority students from low-income families, are discouraged from ever applying to medical school, no matter how much they wish to do so.

According to a 2006 report from the Association of American Medical Colleges (AAMC), the median family income of entering medical students surveyed increased from \$50,000 in 1987 to \$100,000 in 2006. Even at Morehouse School of Medicine, in 1995 the mean family income of our entering students was \$48,500, whereas the mean income for black families nationally at that time was less than \$25,000. Our efforts to recruit and graduate students from low-income communities were not as successful as we had hoped they would be.

More recent data from the AAMC show that the median family income for all first-year medical students in the United States was \$120,000 in 2014. The median income for black families in the same year was \$35,398, according to the Census Bureau. At Morehouse School of Medicine, the median income of first-year medical students (who are mostly minorities) was \$76,000 in 2014—less than the median family income for all US medical students but more than twice that of US black families in general.

When minority students give up their dream of becoming a doctor or other health professional, they are depriving themselves; depriving future patients who would benefit from having a more ethnically and racially diverse health care workforce; and depriving the nation of the contributions they could

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make to improving their lives, their community, and the country.

Another AAMC report, *Altering the Course: Black Males in Medicine*, released in August 2015, found that in 2014 there were twenty-seven fewer black male first-year medical students than there had been in 1978, thirty-six years earlier—a striking observation.

Could having a minority physician help address the startling health disparities observed between whites and people of color? In 1996 Miriam Komaromy and colleagues documented in the *New England Journal of Medicine* that black and Latino physicians are three to five times more likely than white physicians to establish their offices in the ghetto or barrio, providing services to underserved populations. And a report from the Institute of Medicine in 2003, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, documented the conscious and unconscious biases that physicians often have against poor people. Changing the makeup of the health care workforce could change how care is delivered to vulnerable patients.

By allowing our educational system to evolve over the past few decades into one in which so many students in the health professions incur massive debts to support their education, we have also inadvertently created a national environment that has impaired access to health services for too many of our citizens. To more quickly reduce their educational debts, many newly trained health professionals are choosing higher-paying medical specialties instead of primary care for their careers. This has resulted in fewer family physicians, pediatricians, general internists, and psychiatrists than we need.

Developing The Health Workforce The Nation Needs

Given these realities, what can be done to make a career in the health profes-

sions more affordable and the health workforce more inclusive? I believe that the nation's health professions schools must work diligently to avoid increasing tuitions further. This will require greater efforts by trustees, presidents, deans, and others in the schools to secure the needed funds from public and private sources to lessen the burden currently placed on health professions students and their families.

To stimulate and support the expansion of health professions education in the nation during the second half of the twentieth century and to avert a predicted shortage of health professionals, Congress enacted a number of bills in the 1960s and 1970s, collectively referred to as “health manpower” legislation. One of the initiatives developed at that time was the National Health Service Corps, which has a program that provides full tuition, covers the cost of books, and pays a living stipend to students who commit to practicing in a federally designated Health Professional Shortage Area for a specified number of years after completion of their postgraduate training. This program has been very effective in supporting future health professionals and placing them in medically underserved rural and urban areas. Unfortunately, it and other scholarship programs were drastically reduced in the 1980s. The American Recovery and Reinvestment Act of 2009 and the Affordable Care Act of 2010 include significant expansion of the National Health Service Corps scholarship program.

Today many health professions students rely extensively on student loan programs to support their years of training. In its August 2015 report, the AAMC stated that among the students graduating from a US medical school in 2014, mean educational debt was \$178,000, 31.5 percent of the students had total debt of more than \$200,000, and 41.9 percent of black male students had educational debt in excess of \$200,000 (the report did not enumerate medical school debt for female students).

A number of novel programs and initiatives have been rolled out recently, aimed at making health professions education more affordable.

The Uniformed Services University of the Health Sciences, for instance, trains

health professionals for careers in the military services. Because of their military commitment, the students obtain their education at no cost. Military scholarships are also provided to health professions students in many medical schools in return for their subsequent service as health professionals in the military for a defined period.

The Salina campus of the University of Kansas School of Medicine recruits students committed to becoming primary care physicians and working in medically underserved rural communities in Kansas. Through the medical school's Kansas Bridging Plan, some of the students' educational debts are forgiven in return for practicing in these underserved communities. Several states have similar programs for paying off educational debt, including Louisiana's State Loan Repayment Program, intended to encourage primary care practitioners to serve in Health Professional Shortage Areas; and a Minnesota loan forgiveness program to encourage midlevel providers—physician assistants, nurse practitioners, certified nurse midwives, dental therapists, and others—to practice in rural areas.

Over the years, Morehouse School of Medicine has worked to secure funds for student support from public and private

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sources. As a result of their commitment to providing primary care and establishing their practices in federally designated medically underserved areas, nineteen of the twenty-four students in the school's first class received National Health Service Corps scholarships.

Policy makers should evaluate these and other strategies for financing health professionals' education to determine whether they represent viable mechanisms for developing the health workforce needed by the nation, removing financial barriers for low- and middle-income students, assisting in the recruitment of physicians to medically underserved communities, and helping increase racial and ethnic diversity in the nation's health professions. Such investments are necessary to ensure that the talents and skills required for our nation's health system will be there in the future.

A fundamental requirement for a

strong nation is a healthy population. For the United States, this means having sufficient numbers and sufficient diversity of health professionals in urban and rural communities across the country to promote healthy lifestyles and a culture of wellness, and to care for people who are afflicted by illness or injury. In the US health care system, greater racial and ethnic diversity is essential to providing high-quality care, promoting the cultural competence of health professionals, and developing the trust and confidence in health professionals needed by the people served by the system.

There are no longer separate waiting rooms for white and black patients in Blakely. We've made some progress. But if we do not invest sufficiently today in the education of young health professionals, although we now sit in the same room, we may have a very long wait. ■

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