The Geographic and Functional Distribution of Black Physicians: Some Research and Policy Considerations

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Abstract: Studies of the geographic and functional distribution of physicians rarely include race of the physicians as a study variable. For black physicians, there are some rather strong justifications for doing just that: 1) their services are directed almost exclusively to black and often medically underserved communities; 2) recent efforts to reduce constraints to medical education based on race, sex, ethnicity, and income have resulted in a substantial increase in the proportion of black medical students; 3) inferring about black physicians from information on the general population of physicians given the differences in biographical and experiential characteristics is tenuous at best. Hence, an adequate information base and focused conceptualization on the educational and career patterns of black physicians are indicated. At the policy level there is a need to clarify the relationship between equity in educational (and career) opportunity and efforts to redistribute physicians. (Am. J. Public Health 67:519–526, 1977)

Introduction

It is generally agreed that some restructuring of the health care system is required to rectify an inequity in access to health care currently experienced by some segments of the population. Imbalance has been traced, in part, to disparities in the geographic and functional distribution of physicians. For the medical profession as a whole, shortages in certain localities and specialty areas appear to be due as much to maldistributions as to absolute numbers. Corrective efforts include achieving distributional and service equity as well as increasing the supply of physicians. The supply and distributional situation for black physicians differs from that of the general physician population sufficiently to warrant specific attention.

Purpose and Limitations

The intent of this paper is to provide a review of existing information on the geographic and functional (specialty, source of income, and major professional activity) distribution of black physicians as compared to all physicians. The objective is to relate these findings to some of the major issues in health manpower research and to the policy of equity in medical career opportunity.

This effort is tempered by the fact that available data on black physicians, per se, are limited. The American Medical Association (AMA) and kindred data collecting and maintenance organizations rarely identify physicians by race in their public reports. Large tracking projects of medical school graduates such as that of the Association of American Medical Colleges (AAMC) have usually not included the two predominantly black medical schools, Howard University and Meharry Medical College. Hence, there are few black physicians among their study cohorts. Major analytical studies have rarely included race of the provider as a study variable. This lack of emphasis is, perhaps, understandable in terms of the small number of black physicians in relation to the total physician population. It overlooks, however, the concentrated services of black physicians to a significantly underserved population. There have been, however, several histories, descriptive studies, and commission reports focusing on black physicians which along with selected aggregate data will be referenced in this article.[1–4]

Topical references and comparisons between the rather voluminous body of literature on the general physician population and black physicians are made with two important considerations in mind. First, aggregate data on the general physician population have been criticized as misfocused and providing insufficient explanation of the professional behavior of physicians. Many of the individually based studies are narrowly focused and lack comparability because of variations in definitions and methodologies.[5–9] Second, given the tremendous difference in the base numbers of black physicians and the general physician population, comparison could be misleading if not properly interpreted, i.e., only about 2 per cent of the 380,000 physicians in the United States are black.[5]

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Further, black physicians operate in what approximates a separate market, i.e., their services are mainly to black clients.[1-4] Thus the geographic and functional distribution of black physicians must also be considered in relation to the black population.

Background

The last ten years have been marked by foundation, medical association, and federal initiatives to increase the number of minority students in medical schools. In 1970 the AAMC endorsed the statement that: ". . . Medical schools must admit increased number of students from your geographic areas, economic backgrounds and ethnic groups that are now inadequately represented."[10] The AAMC also noted that the need for financial assistance is a major barrier to minority students hoping to attend medical school and further urged that funds available for this group be increased.[10] Although some limited programs and individual level assistance are available from private sources, most of the funds for achieving this objective are federal.[10-15] Section 774(b) of the Comprehensive Health Manpower Act for 1971, for which authorization expired in 1974, specified support for public or nonprofit private health and educational entities to establish and operate projects designed to identify, motivate, recruit, and retain socioeconomically and educationally disadvantaged individuals interested in or pursuing careers in the major health professions. Section 772(a), which covered special grants and contracts to public or private health or educational entities, had as one of its components the provision of aid to minority or low-income students. The Health Professions Student Assistance Program (HPSAP) also under this legislation had as a primary objective increasing the number of students from low income families in the health professions although a government sponsored evaluation indicated that this group was not a major beneficiary of the program.[10-15] Even so, the overall number of black medical students and those not in predominantly black medical schools increased significantly. From 1968 to 1974 enrollment of black students increased from 2.2 per cent to 6 per cent of the total medical school enrollment. The figures for the first year students for the same period rose from 2.7 per cent to 7.2 per cent.[11-12] The slight drop in the percentage of first year enrollees for 1975 (6.8 per cent) coincides with the expiration of legislation for special programs and has been attributed to the increasing unavailability of financial aid which is a necessity for a large percentage of minority medical school applicants.[16-17]

In October 1976, the Health Professions Educational Assistance Act of 1976 (P.L. 94-484) was signed by the President. This legislation places greatest emphasis on federal support of efforts to achieve geographic and specialty redistribution. While it consolidated and slightly increased categorical support (Sec. 787) to schools and other entities that might assist disadvantaged applicants in gaining admission into and completing medical training, most of the loan and scholarship provisions for direct student support are tied to service incurment and primary care training. The HPSAP providing unconditional assistance to needy students was not reenacted.[14-15]

There has been much less direct intervention and monitoring at the internship, residency, and practice levels. The Civil Rights Law of 1964, especially Titles VI and VII (as amended in 1972) and Regulations of the Department of Labor, Revised Order Number 4, require all institutions (including hospitals) receiving government funds to provide equal service and employment opportunity and to document their affirmative actions. The Civil Rights clauses of Medicaid, Medicare, Revenue Sharing, and other federal programs have similar stipulations. The enforcement and impact of these laws and regulations on the graduate training of black physicians have not been systematically assessed. However, there has been a steady increase in the number of black physicians appointed to graduate training programs, and a preliminary report of a success rate comparable to all physicians in obtaining desired internship placements has been published.[18] The effect of these laws and regulations on hospital privileges and other aspects of the medical activities of black physicians has not been ascertained.[1]

Geographic Distribution

Regional

As with the general population of physicians, the present supply of approximately 6,000 black physicians is disproportionately concentrated in certain localities.[19-23] As indicated in Table 1, the distribution of all physicians in relation to the general population is more congruent than that of black physicians to the black population at the regional level. This is especially the case for the South, the Middle Atlantic division of the Northeast, and the Pacific division of the West. Only 32 per cent of the active black physicians are in the South even though 53 per cent of the black population resides there. By contrast, the percentages of black physicians in the Pacific and Middle Atlantic divisions (13 per cent and 29 per cent) are almost double the percentages of the black population (7 per cent and 17 per cent). The geographic distribution of black interns and residents is closer to that of the black population. Whether or not this is a temporal training artifact remains to be seen. Migration information does, however, point to a temporal effect.

Although overall black physicians intra- and inter-region migration rates are similar to those of the general population of physicians, the pattern of the migration differs (Table 2). There are higher percentages of intra-regional moves among the general population of physicians in every region except the West. The inter-regional movement of black physicians is more focused, i.e., there is apparently a strong tendency for those moving inter-region to move to the South. However, the impact of this southward migration is offset by the high absolute-to-total number of black physicians from the South who move to other regions. The seemingly heavy loss of black physicians from the South may be attributable to the location of the two predominantly black medical schools in this region or to more generalizable population dynamics.

Urban-Rural and Intra-Urban

Urban-rural differences in the distribution of the general and black populations, and of all physicians and black physi-

TABLE 1—Number and Per Cent of all Active and Black Physicians, and Per Cent of All and Black Population in the United States by Geographic Region and Division

Geographic Region and Division	All Active Physicians, 1972		U.S. Population 1972	Active Black Physicians, 1970		Black Interns and Residents, 1973		U.S. Black Population, 1970
	Number	Per Cent	Per Cent	Number	Per Cent	Number	Per Cent	Per Cent
Northeast	93,584	29	24	1,861	31	316	23	19
New England	23,047	7	6	111	2	59	4	2
Middle Atlantic	70,537	22	18	1,750	29	257	19	17
South	85,984	27	31	1,921	32	616	45	53
South Atlantic	47,984	15	15	1,324	22	358	26	28
East South Central	13,828	4	6	358	6	111	8	11
West North Central	24,307	8	10	259	4	147	11	13
North Central	72,861	23	28	1,336	23	228	17	20
East North Central	53,023	16	20	1,172	20	159	12	17
West North Central	20,838	7	8	164	3	69	5	3
West	63,093	20	17	846	14	204	15	8
Mountain	12,821	4	4	41	1	12	1	1
Pacific	50,272	16	13	805	13	192	14	7
U.S. Possessions	5,381	2		unknown				
TOTAL	320,903	100	100	5,964	100	1,364	100	100

Source: All Active Physicians—American Medical Association, Distribution of Physicians in United States—1972. Populations—U.S. Department of Commerce, Bureau of Census, General Population Characteristics, PC(1)—B1. Black Physicians—U.S. Department of Commerce, Bureau of the Census, Occupational Characteristics, PC(2)—7A*. Black Interns and Residents—Medical Education, *Journal of the American Medical Association Supplement* 1975, Vol. 23.

*These and all Census data regarding occupation are based on at most a 20 per cent sample of the indicated population. The questions on which the data are based are self reported by individual or members of their families in terms of their primary employment activity.

cians are evident in Table 3. A larger percentage of black physicians reside in urbanized areas: 92 per cent compared to 76 per cent. The urban-rural distribution of black physicians in relation to both total and black population is even more discongruent than that of all physicians in relation to total population. Only 8 per cent of black physicians are in other urban (nonmetropolitan) and rural areas, while 30 per cent of the black population resides in such places.

Though often hidden by data based on an entire metropolitan area, and not controlled for specialty, the intra-urban distribution of physicians is often more unbalanced than between urban and rural areas. For socio-cultural and professional reasons, there is an accelerating exodus of primary care physicians, especially from the central city to the urban fringes.[24] Also, there is evidence that physicians avoid predominantly low income and black areas.[25-28] By contrast, black physicians in urbanized areas overwhelmingly reside in the central city.

Explanatory Efforts

Studies attempting to identify the factors influencing the spatial distribution of physicians are broadly categorizable into those emphasizing characteristics of the environment in relation to aggregate physicians and those focusing on individual physicians in terms of collective characteristics, opinion, and other psychosocial factors. Among the environmental characteristics, degree of urbanization and level of residents' income are reported to be the chief determinants. Other determinants include racial composition of the service population, climate, coastal location, and proximity to hospital and medical school facilities.[7,22,25,28-30]

At the individual level, findings suggest that, compared to their urban counterparts, physicians in rural practice are more positive toward life in rural areas, older, less likely to be board certified, and more likely to have had prior contact in similar settings.[31-34] Although this type of research has, perhaps, greater potential for providing insight into the behavioral dynamics of career decisions, results are generally considered inconclusive, as noted earlier, because of their definitional variability, narrow focus, and eclectic methodologies.

In contrast to these explanations, the literature on black physicians suggests other *probable* major influences on their geographic location. First, 80 per cent of the black physicians have graduated from two medical schools, Howard University in Washington, D.C. and Meharry Medical College in Nashville, Tennessee, both predominantly black schools.[10-21] Another substantial percentage of older black physicians graduated from now defunct black medical schools located mainly in southern cities.[1-4] Although on the increase for a number of years, 1974 was the first time in history that the number of black medical students in other medical schools exceeded those in Howard University and Meharry. Still, of 114 medical schools, these two enroll more than 25 per cent of all black students.[11-12,19-20] Further, information on the legal residence and location of medical students by race indicates that black medical students are less apt to attend medical school in their home region.[11] For example, 88 per cent of reporting white students entering medi-

TABLE 2—Physicians*: Residence in 1965—Residence in 1970

Residence	All Physicians Number	All Physicians Per Cent	Black Physicians Number	Black Physicians Per Cent
Same Region	213,246	84	4,365	84
Same State	197,246	78	4,070	78
Different State	15,965	6	295	6
Different Region	24,178	10	411	8
Living Outside U.S.	14,783	6	415	8
**Total	252,207	100	5,191	100
Mobility (moved only) Northeast in 1965				
Intra region	4,667	42	55	34
North Central 1970	1,934	17	18	11
South 1970	2,664	24	63	38
West 1970	1,835	17	27	17
TOTAL MOVED	11,100	100	163	100
North Central in 1965				
Intra region 1970	3,885	34	16	15
Northeast 1970	1,545	14	22	22
South 1970	2,477	22	44	44
West 1970	3,351	30	19	19
TOTAL MOVED	11,258	100	101	100
South in 1965				
Intra region	5,520	45	130	41
Northeast 1970	2,586	21	59	19
North Central 1970	2,403	19	106	34
West 1970	1,901	15	20	6
TOTAL MOVED	12,410	100	315	100
West in 1965				
Intra region	1,893	35	94	74
Northeast 1970	952	18	—	—
North Central 1970	1,013	19	33	26
South 1970	1,517	28	—	—
TOTAL MOVED	5,375	100	127	100

Source: U.S. Department of Commerce, Bureau of the Census. *Occupation Characteristics* Pc(2)-7A.
*Physicians, Medical and Osteopathic
**Only those who reported residences

cal school in the Northeast in 1971–1972 listed it as the region of residence while this was the case for only 67 per cent of the black students. The overall regional congruency in legal residence and medical school was 87 per cent for white students and 71 per cent for black students.[11]

Second, black physicians tend to locate where there is the greatest growth in black population.[35–38] While this might suggest proportional distribution eventually, this may not prove to be the case, for it also appears that they migrate selectively to those areas where the median income of black families is relatively high and income and other quality of life differentials between white and black families are relatively low (in the South in 1969 the income of black families averaged 57 per cent of that of white families compared to 73 per cent outside that region[35–38]).

Third, since black physicians must be concerned about minimizing social as well as professional discrimination, regardless of place of origin or training, they are more likely to migrate or settle in those areas where they will encounter less discrimination in the sense of its relative absence and/or not have to interact with the non-black professional and social community.[1–4, 19–20, 35–39]

Fourth, the migration practices of the black population compared to those of the rest of the population appear to be more influenced by location of relatives and friends. There is some evidence that these practices and their bases hold for black physicians as well, i.e., the comparative greater risks and strains from exposure to a new, unknown environment.[35–38] There is further support for this selective migration proposition in the fact that since a majority of black physicians are from the two predominantly black medical schools and before that from a few select black colleges, they approximate a social as well as a professional group.

Finally, as mentioned earlier, there is the matter of the consumers of the health services delivered by black physicians. In sociological parlance, black physicians have an auxiliary status characteristic, race, which makes for ambiguity in role qualifications.[39] For a number of reasons rooted in discrimination and prejudice, the patients served by black physicians are overwhelmingly black and are likely to be so for some time.[1–4] Discrimination and prejudice vary by community, and it has been hypothesized that communities with histories of nondiscrimination in the delivery of health services to black citizens and/or restricted opportunities for black physicians are not likely to attract or retain many black physicians.[36] Compared to whites, black families have substantially lower expenditures for physician services. Also, blacks in the aggregate make fewer physician visits than whites and a larger percentage of the visits are episodic.[40]

Functional Distribution

Specialty

Access problems created by geographic maldistribution are intensified by specialization. Specialists are generally more unevenly distributed geographically than the general population of physicians, concentrated around medical centers and schools in urban areas and often inaccessible to many of those requiring primary care. Some manpower experts estimate an oversupply or near sufficiency in some medical specialties and a gross undersupply in others, especially the primary care ones.[8, 22] Moreover, there are some indications that, once in the field, an increasing number of primary care physicians are restricting their practice to subspecialty areas.[41]

According to available information, black physicians differ appreciably from this profile of the census of physicians. Data from a National Medical Association Foundation (NMAF) census survey show that 30 per cent of all practicing black physicians are in general practice or family medicine compared to 18 per cent of all physicians (Table 4). The percentage of black physicians in the medical and surgical specialties is similar to that of all physicians but there are smaller

TABLE 3—U.S. and Physician Population Urban and Rural Residence by Race: 1970

Residence	U.S. Population	All Physicians		Black Population	Black Physicians	
	Per Cent	Number	Per Cent	Per Cent	Number	Per Cent
Urbanized Areas	59	194,198	76	70	4,796	92
Central Cities	32	101,686	40	59	3,766	72
Urban Fringe	27	92,512	36	11	1,030	20
Other Urban Areas	15	31,799	12	11	245	4
Rural Areas	26	29,427	12	19	217	4
TOTAL	100	255,421	100	100	5,258	100

Source: Population—U.S. Department of Commerce, Bureau of the Census, *General Population Characteristics*, PC(1)-B1.
Physicians—U.S. Department of Commerce, Bureau of the Census, *Occupational Characteristics*, PC(2)-7A.

percentages in the other specialties, (e.g., psychiatry, neurology, pathology, physical medicine, and radiology.)

Specialization plans of 1972–1973 medical school matriculants by race suggest a probable modification in this pattern; only 8 per cent if the black students have no plans for specializing. However, 41 per cent of the black medical students compared to 30 per cent of their white counterparts plan to specialize in primary care areas.[11]

Class of Worker, Activity Mode

In the area of employment, black physicians are somewhat more likely than the general physician population to be salaried—47 per cent compared to 42 per cent for all physicians—and to be employed by the government, 22 per cent compared to 15 per cent (Table 5). In practice modality, 7 per cent of black physicians are in hospital-based practice and 4 per cent in group practice while the comparable figures for all physicians are 23 per cent and 17 per cent respectively. Only 60 per cent of the black physicians are in direct patient care, considerably less than the figure of 91 per cent for all physicians. Correspondingly, the percentages of black physicians engaged in teaching, research, and other medical activities is higher.*

Data on black medical school matriculants suggest a possible change in the mode of practice. The percentage of black students planning to be active in private group and hospital-based group practice was 37 per cent compared to 31 per cent for white students. Also, 14 per cent of black medical students compared to 5 per cent of the whites planned careers in public health. The latter finding reflects a continuance of the tendency for black physicians to be salaried.[11]

Regionally controlled data from a limited 1969 sample survey of National Medical Association (NMA) members show that black physicians, like all physicians in the Northeast and West compared to those in other regions, are more likely to be involved in some form of patient care other than general practice. The South had the lowest percentage of board certified black physicians. The percentage from this

TABLE 4—All Active Physicians and NMAF-Black Physician Respondents by Specialty Group

	All Physicians		Black Physician Respondents	
	Number	Per Cent	Number	Per Cent
General and Family Practice	57,948	18	1026	30
Medical	72,214	25	727	21
Surgical	86,042	28	943	27
Other	89,641	29	707	21
TOTAL	310,845*	100*	3405*	100

Source: American Medical Association, Center for Health Services Research and Development Center, *Reference Data on the Profile of Medical Practice*, 1971.
National Medical Association Foundation Survey of Black Physicians, 1972.
*Excludes inactive and unclassified physicians and those who could not be contacted.

TABLE 5—Physicians: Class of Workers/Source of Income

	All Physicians		Black Physicians	
	Number	Per Cent	Number	Per Cent
Private Wage and Salary Worker	73,048	29	1,327	25
Government	38,620	15	1,126	22
Self-Employed	143,122	56	2,763	53
TOTAL	254,790	100	5,216	100

Source: 1970—Subject Report—U.S. Department of Commerce, Bureau of the Census Social and Economic Administration. *Occupational Characteristics*. PC(2)-7A.

*A partial explanation for this rather surprising statistic may be geographical bias in the returns to the survey from which these data are derived. The return rates were slightly higher from the District of Columbia and Tennessee where the two predominantly black medical schools and several black owned or controlled hospitals and health related institutions are located; they were lower from New York, Illinois, and Pennsylvania, states that have substantial black physician populations thought to be mainly involved in direct patient care.

region reporting hospital staff privileges (60 per cent) is fairly consistent with that of all physicians and across regions. There were, however, clear distinctions in the regional distribution of full-time staff affiliation: Northeast 27 per cent, West 18 per cent, Midwest 9 per cent and South 13 per cent.[42] These data, however, do not specify affiliation with which hospitals, i.e., control, size, and with what options.*

Explanatory Efforts

Unlike geographic location studies, attempts to identify the factors associated with specialty choice and activity mode have concentrated mainly on incentives, training, background, and personality characteristics.[33, 43–45] In a study of five classes from Johns Hopkins, it was found that students choosing general practice tended to be relatively low in academic standing. Other studies have found that graduates of public and relatively less selective medical schools are more likely to be general practitioners.[31] A few studies have related faculty and other role models to eventual specialization and mode of practice.[46]

Perception studies are based on the premise that an individual's construction of reality as well as objective fact determines response. Along this line specialty stereotypes have been investigated. The implicit assumption is that students tend to identify with particular models in a self-fulfilling and perpetuating manner.[47] In terms of student personality traits, one study found that students choosing general practice scored high on an authoritarianism scale, while those high on Machiavellianism preferred psychiatry and rejected general practice.[48]

Socioeconomic differences have been shown to exist between students/physicians choosing general practice over all other specialties, with general practitioners tending to come from less favorable economic and social backgrounds. A significant proportion of general practitioners come from small towns or rural areas and were married before graduation.[49, 50]

Sex of the individual has also been related to specialty choice and activity, and some of the relationships seem, at least superficially, akin to the situation of black physicians. Female matriculants and physicians more often express interest and practice in primary care areas and are more likely to be salaried. Frequently reported reasons include personal contact orientation, discrimination, and role conflict.[51–54] A larger proportion of the black than white matriculants are married and almost one-third are from families wherein the reported parental income is less than $5,000 per year. Black matriculants are more likely to be female (nearly one-fourth) and generally have lower test performance.[11–13, 17, 36] The implications of these characteristics for black physicians can not, however, be inferred from studies in the general physician population or female physicians.

Black physicians operate within a confined opportunity structure. The largely segregated market in which they work is often characterized by competition for patients between solo practitioners and specialists. Frequently, black specialists are forced to restrict or abandon work in their specialty area for general practice.[3, 36] Thus salaried positions, other incentives notwithstanding, become more attractive. At a psychological level any attempt to explain the professional behavior of black physicians would have to take into account the pervasive effects of minority group status.[39]

Some Specific Research and Policy Considerations

As outlined previously, there is heightened recognition of the need to reduce the inequity in educational opportunity in the medical profession. There is also an overriding concern about the maldistribution of physicians. In this connection the implicit if not explicit assumption is often made that black physicians will assist, out of proportion to their numbers, in alleviating the shortage of primary care physicians in underserved, mainly black communities.[17, 35, 55] This assumption, whether intended or not, is operationalized by basing financial support of medical training on service incurment and specialty designation. Black applicants to medical schools are more likely to be needy. Hence, they are more apt as a group to request loans and scholarships with specialty and service stipulations. Their willingness to do this is further conditioned by the fact that much of what is designated as underserved areas and specialty shortages falls within their "natural market," i.e., inner city communities and primary care specialties. Further, the stringent repayment clauses for default of service commitment will probably cause greater hardship for medical school graduates from low-income families. For these reasons, an investment in black physicians seems likely at first glance to have a disproportionately positive effect on the availability of physicians, especially primary care physicians, in certain black communities.

The reasoning behind such a conclusion, however, raises a number of related questions. What will be the locational and functional redistributional effects on black physicians and, by extension, on underserved areas? Is there also a more fundamental question about the continuing acceptance (or more correctly the non-rejection) of a mainly segregated market for black physicians? Is the espousal of black physicians serving the black community (especially low-income black communities) a legitimate goal or standard with the optimal ratios similar to physician-population ratios for the general population? Some possible rationales for this are client preference and receptivity; *supposed* service motives and predilections of black physicians; a vested interest in segregation; and the less frequently mentioned one of choice.

The information and comments presented in this article clearly indicate that these and related questions and issues about black physicians cannot be adequately addressed from the existing data base or from the perspective of the general physician population. At the same time, the need to address them is essential to efforts to increase the representation of black physicians in the general physician population and to improve accessibility to health services.

An adequate, updated information base is an obvious

*This and other issues touched on in this article will be addressed directly in a forthcoming national survey of black physicians by Meharry Medical College.

first requirement for addressing these issues. Some of the particulars of developing such a base can be guided by what is known. For instance, since black physicians are overwhelmingly urbanized, data should be especially sensitive to their location within urbanized areas. Also, since the last ten years or so have seen significant changes in the educational and career options of minorities, information should be time-controlled, and relevant public policies, law and regulations should be noted. At another level, it will be necessary to identify the complex of ecological and experiential factors which affect the geographic and functional distribution of black physicians. These must be considered within the context of the intergroup relationship of localities and from the perspective of black physicians and students. Emphasis should be placed on those factors which are conducive to intervention.

At the policy level, even in the absence of an adequate data base, some attention can be given to the relationship between increasing black representation in the medical profession and improving access to health care. This should take the form of clarifying the position that equity in education and career opportunity is a sufficient goal in itself. As a corollary, the maldistribution and inequity in health services—whether in rural or urban area, to black or white people, in a particular region of the country, or in specialty or activity—are no more the problems of black physicians than they are of all the personnel and institutions of the entire health care complex.

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Medical Care

In every part of the world, medical care is now coming to be regarded not as a purchasable private commodity but as a civic right and a public service.

Alan Gregg, quoted in Penfield, Wilder. The Difficult Art of Giving—The Epic of Alan Gregg, Boston: Little, Brown and Co., 1967, p. 333.

Ed. Note: Contributed by Dr. Fred B. Rogers