MEDICAL EDUCATION IN ATLANTA AND HEALTH CARE OF BLACK MINORITY AND LOW-INCOME PEOPLE

Asa G. Yancey, Sr., MD
Atlanta, Georgia

In this W. Montague Cobb lecture, the author addresses the status of hospitals for the black minority and the poor in Atlanta, the founding of Morehouse School of Medicine, health care for the disadvantaged, the need for minority health care professionals, and the lack of health insurance among the poor. A greater educational effort is needed to bring about change in the high incidence of homicide, the unhealthy lifestyles, and the disproportionate number of AIDS cases in the black population.

During the 1967–68 fiscal year of the National Medical Association (NMA), W. Montague Cobb, MD, PhD, very appropriately recommended and initiated the concept that the NMA meet in Atlanta, Georgia, in the year 1970. The NMA was founded by Miles V. Lynk, MD, at the First Congregational Church in Atlanta in October 1895, and, hence, 1970 was to be the 75th anniversary of the National Medical Association. The NMA is expected to convene in Atlanta for its 100th anniversary in 1995. At its annual meetings, the NMA seeks the active cooperation of local medical schools. Emory University School of Medicine was the only medical school in Atlanta at that time.

Dr. Yancey is Medical Director, Grady Hospital, and Associate Dean, Emory University School of Medicine, Atlanta, Georgia. Presented as the Fourth W. Montague Cobb Annual Lecture Series at the 92nd Annual Convention and Scientific Assembly of the National Medical Association, August 1–6, 1987, New Orleans, La. Sponsored by Ciba-Geigy Pharmaceutical Corporation. Requests for reprints should be addressed to Dr. Asa G. Yancey, Sr., 2845 Engle Road, NW, Atlanta, GA 30318.

W. MONTAGUE COBB

As a member of the faculty and active medical staff of Emory-Grady, the author felt that it would be appropriate to present a paper on the contributions of black physicians to medicine in the United States as the Diamond Anniversary of the NMA approached. Fortunately, the contributions of black physicians to medical knowledge were not lost, nor dependent on the passage of this valuable information from generation to generation by word of mouth.

Dr. Cobb was editor of the *Journal of the National Medical Association* (JNMA) from 1949 to 1977 (personal communication, Dr. Cobb, July 1987). Prior to becoming editor of the journal, during those 28 years and thereafter when he became editor emeritus, he published some 1,113 scientific, biographical, editorial, public health, medical, organizational, and historical articles.

A very large number of Dr. Cobb's writings were narratives of the contributions of Negro physicians to medicine, which were published in JNMA. As resources they were sought after to help summarize the work of black physicians in the United States.

The early issues of the journal, which was started in 1909 with Dr. C. V. Roman as editor-in-chief and Dr. John A. Kenney as associate editor, were sought in the libraries of

Atlanta, but the only library that contained these volumes from 1909 forward was the medical library at Emory University School of Medicine. Since its founding in 1975, Morehouse School of Medicine has been accumulating issues of the journal as well as other historical works on black physicians.*

As a musician, Monty frequently entertained in the home of Dr. Dibble, uplifting the spirits of visiting clinicians to the John A. Andrew Clinical Society meetings in Tuskegee, Alabama, by playing his violin during the evening. As an anthropologist, Monty reminded birth control and family planning specialists of the difficulties they should expect to encounter when trying to educate the public in family planning, for, indeed, the pelvis was very frequently the victor when pitted against the brain in matters of reproduction.

In a more serious vein, Dr. Cobb was professor of anatomy for more than 4,000 medical and dental students and some 2,000 paramedical individuals. In addition to his work as editor, he strongly supported the efforts of the NAACP, serving as President of the Board of Directors from 1976 to 1982 and as a member of the Board from 1950 forward.

At the Imhotep conferences and visits with Presidents Kennedy and Johnson, Dr. Cobb was instrumental in educating these Presidents as to the need for hospital integration in America. President Kennedy readily admitted at one such White House conference that he was unaware of racial segregation in southern Catholic hospitals and was surprised that such existed. Baptists, Methodists, and other denominational hospitals were rigidly organized along segregated lines.

In 1962, Dr. Cobb led an effort within the National Medical Association that resulted in the organization's endorsement of Medicare. Thus the NMA became the first national body of physicians to endorse this now highly accepted federal health insurance for those aged 65 years and older.

Dr. Cobb was President of the National Medical Association in 1964–65. His supplement to the December 1981 issue of the journal that was entitled, "The Black American in Medicine," has been widely distributed and acclaimed as a most timely summary on that subject.

BLACK HOSPITALS

Negro hospitals were a necessity in the horripilant days of legalized segregation, which was upheld by the US Supreme Court in the case of Plessy v. Ferguson in 1896, thus firmly establishing racial segregation in the mores of this nation from the end of slavery in 1865 to the 1954 US Supreme Court decision to desegregate the nation. It is estimated that, over the past one-half century, more than 200 Negro hospitals have closed,[1,2] and in the past 25 years, approximately 62 black hospitals have closed. At present, only about 12 to 15 such hospitals exist in the United States. Other estimates are that there are 12 Afro-American hospitals currently in existence, and that approximately 51 such institutions have closed since 1961; another 14 were converted or consolidated.

About 30 percent of the black population have no health insurance or are underinsured, compared with 14 percent of the general population. With less cash flow, these institutions were forced to compromise in the purchase of the latest, most effective, and most expensive equipment for diagnostic and therapeutic purposes. Affluent black patients moved to the periphery of the major cities and to the suburbs, as did whites of comparable income, who moved several years prior to the outward mobility of the black families. The inner-city black hospitals had an increasingly smaller number of physicians and a smaller patient population with adequate hospitalization insurance. Some of the leading Afro-American hospitals that closed were Mercy-Douglas in Philadelphia, Kate Biting Reynolds in Winston-Salem, and Flint Goodridge in New Orleans, to name a few.

In Atlanta, there are three predominantly black hospitals. The Hughes Spalding Medical Center has 124 beds and is in debt. Its low bed-occupancy percentage has resulted in efforts to market its services, and it has associated itself with the Morehouse School of Medicine. The Physicians and Surgeons Hospital in Atlanta lists 184 beds, but it, too, suffers a low bed-occupancy percentage. It has changed ownership several times and continues to be in poor economic straits. Both hospitals, however, provide good medical treatment at the level of care expected of a community hospital. The Southwest Hospital and Medical Center has a better bed-occupancy percentage than the two previously named hospitals, but it is in need of increased admissions. It also provides sound, high-quality medical care at the level of a community hospital. None of these three hospitals functions at a level of tertiary care or provides services such as organ transplantation and open heart surgery. Nor can they serve in the vanguard of medical knowledge for a fully accredited education of medical students and residents in most of the major medical specialties.

* Morehouse is seeking back issues of the *Journal of the National Medical Association* from 1909 to 1975. Mail to: Morehouse School of Medicine, 720 Westview Drive, S.W., Atlanta, GA 30310.

MOREHOUSE SCHOOL OF MEDICINE

The Morehouse School of Medicine was founded in 1975 on stimulus from Louis C. Brown, MD, a past President of the Georgia State Medical Association. The medical school began as a two-year institution in 1978 and graduated its first class in 1980. In July 1982, the Basic Science medical building was dedicated. Development has been sound, excellent, and rapid, and the first MD degree was conferred upon students at the Morehouse School of Medicine in 1985.[3] In May 1987, 25 students received the MD degree from the Morehouse School of Medicine. On May 15, 1987, the second Morehouse School of Medicine building was dedicated, a new medical education building.

Morehouse medical students (many of whom are not accepted by other medical schools) are required to pass parts I and II of the examinations given by the National Board of Medical Examiners, and 93 percent completed part I successfully, with 99 percent passing part II. This is as good or better than some of the nation's leading schools of medicine.

The Morehouse School of Medicine has always operated in the black, economically. Only recently was a $15,000,000 national fund-raising campaign successfully completed. Research and sponsored programs, including the Title III award and the matching funds from the state of Georgia, totaled $10,971,991. The total amount of research and educational grants received for the fiscal year 1987 was over 5 million dollars.[4]

The Ciba-Geigy Pharmaceutical Corporation has also shown an interest in supporting biomedical research at the Morehouse School of Medicine. Grady Memorial Hospital, a large, 940-bed, public teaching institution, owned by Fulton and DeKalb counties, is used by the Morehouse School of Medicine for the teaching of its students.

Emory University, Morehouse School of Medicine, and The Fulton-DeKalb Hospital Authority (Grady Memorial Hospital) entered into an agreement, beginning July 1, 1984, whereby the Morehouse School of Medicine would be a partner with equity at Grady Memorial Hospital, which is the prime teaching hospital for Emory University School of Medicine and the Morehouse School of Medicine. This contract is continuing and is working well with unitary services being maintained at Grady Memorial Hospital and the faculty members of both medical schools being members of the active medical staff. On a temporary basis Emory University provides the teaching for the entire third year for the Morehouse medical students, and the Morehouse School of Medicine instructs these individuals for the first two years and the fourth year. The Morehouse clinical faculty is expected to grow rapidly from its present number of 20 at Grady Memorial Hospital and to progressively and increasingly become more involved in patient care, the supervision of house officers, the teaching of medical students, and in clinical research. Morehouse School of Medicine students have received excellent residencies in the nation's leading hospitals upon graduation.[3]

In addition to a partnership at Grady Memorial Hospital, Morehouse is in great need of an academic hospital over which it has control. The chairmen of the clinical services at Morehouse have the responsibility of leadership in teaching, in supervision of its residents, and in patient care and clinical research so that the school may grow in stature nationally.

Most cities find it difficult to maintain *one* private inner-city hospital that is predominantly black, as evidenced by the current experiences of Provident Hospital in Chicago and the old Provident Hospital (now Liberty Medical Center) in Baltimore. With only one such Afro-American hospital in the above-named cities, each is having difficulty surviving economically; hence, three predominantly black private hospitals in Atlanta is indeed a curious situation.

In metropolitan Atlanta there are over 15 predominantly white hospitals that are essentially private, and although the population of blacks in metropolitan Atlanta is such that arithmetically three hospitals should be able to survive and perform well, economically this is just not the case. This is largely because of the economic status of the Afro-American population and other factors, such as the relatively small number of black physicians present. Accordingly, it is logically and strongly recommended that (1) in time, the Hughes Spalding Medical Center be closed (use the space for research and offices) and its approved/certified 124 beds be allotted to a Morehouse School of Medicine hospital, (2) the 130 approved/certified beds of the Southwest Hospital and Medical Center be allotted (may expand as an MSM hospital, as appropriate) to a Morehouse academic hospital, and (3) the privately owned, for-profit hospital, the Physicians and Surgeons Hospital, be closed and those 184 certified/approved beds[5] be allotted to the Morehouse School of Medicine. Thus, there would be a total of something over 400 beds for a major hospital under the leadership of the Morehouse School of Medicine. Morehouse would continue as a partner, with equity, at Grady as previously stated.

As medical knowledge increases, more health care will be delivered on

continued on page 473

continued from page 469

an outpatient basis; hence, hospitals will become institutions for progressively more complicated medical, procedural, surgical, diagnostic, and therapeutic care. There will likely be less need for the small community hospital, regardless of race, and, therefore, all the more reason exists to abolish these three community hospitals—over and above the economics of hospitalization—and to establish as promptly as humanly possible an academic hospital for the Morehouse School that will serve community physicians under the leadership of a Morehouse faculty. This would be a giant step forward for the Morehouse School of Medicine. As its Chairman of the Board of Trustees, Clinton E. Warner, MD, has often stated, Morehouse will not be among the largest medical schools in the nation, but it will be among the best.

HEALTH CARE AND THE DISADVANTAGED

Poverty and limited education are hazardous to the health of the people in the United States and around the world regardless of race.[6] The increase in cancer mortality has been significant in male blacks, who are among the lowest on the socioeconomic scale. The high incidence of cancer in black patients is probably not genetic or biological, but, rather, is based on socioeconomic factors[7] and lifestyle, as increases in cancer of the prostate, cervix, lung, and esophagus are noted among the socioeconomically deprived.

In 1985, Quitman County in Georgia had the lowest per capita income of any county in the United States.[8] The life expectancy of the black man in Quitman County in 1985 was only 49.6 years, compared with 65.3 years for the national life expectancy of the black man. The life expectancy of the white man in Quitman County in 1985 was 62.2 years; the national life expectancy of the white man was 71.8 years. Similarly, the black woman had a life expectancy of 72.3 years in Quitman County and 73.7 years nationally; while the white woman had a life expectancy of 72.2 years in Quitman County and 78.7 years nationally.

Furthermore, poor people know of the presence and accessibility of the public teaching hospital in their communities, yet they report for health care of conditions such as breast cancer and carcinoma of the cervix later than do higher income individuals. Six times more breast cancer patients present to Grady Hospital (a large, public hospital for the poor) with distant spread of cancer than in other metropolitan Atlanta, Fulton, and DeKalb county private hospitals.[9]

The reasons for such delay are complex: there is less personal attention; long waiting periods for service; difficulty in travel to and from the hospital; less education regarding the value of prevention and early treatment of disease; a realization that there will be some small expense associated with a visit to the hospital, which may diminish significantly the patient's hand-to-mouth monetary existence; fear of being told of the presence of a devastating disease; a false human hope that all will be well tomorrow; and other factors of motivation that are unknown at this time.[9]

A wealthy woman who has a breast mass may have the surgery the next day, whereas care in a large public facility may be delayed for a few weeks as appointments are made for mammography, needle biopsy, etc. The wait at public institutions is being reduced, but even so, the time and inconvenience factors favor the private patients with adequate health care insurance.

MINORITY HEALTH CARE PROFESSIONALS

Minority health care professionals are indeed in short supply the nation over. The number of black medical school graduates in 1986 was 824, or 5.1 percent of the total graduating classes[10] in the nation. Forty-four percent of black applicants were accepted to medical schools in 1986, compared with 55 percent of all applicants. The percentage of minorities in the total number of residents in graduate medical education was 6.64 percent for the southern region of the country, and 8.85 percent for the western sector. The percentage of black minority medical students for 1986–87 in all 127 medical schools was 5.9 percent. Emory University-Grady Memorial Hospital had a commendable 11 percent black minority resident enrollment in 1980–81, 7.6 percent in 1985–86, and has a 8.58 percent enrollment for the academic year 1987–88.

The percentage of residents in the Emory-Grady system of graduate medical education has been consistently higher than the number of black medical students in the schools of medicine throughout the entire nation. Although these figures are encouraging, we still have to increase immensely the number of black medical students and residents.

The percentage of the black population in the state of Georgia is 26 percent. There are about 28 white physicians to every one black doctor,[11] with approximately one white physician to each 540 persons, and one black physician for each 4,100 persons.[12] The percentage of Afro-American physicians of the total number of the nation's doctors is fewer than 3 percent, whereas the Afro-American population is about 12 percent.

Racial segregation is in no way ad-

vocated in health care, but even greater efforts must be made to increase the number of minority health professionals. Lest we forget, in Durban, South Africa,[2] there is one white physician for each 300 white citizens, compared with one black physician for each 91,000 black persons. The average life expectancy for the South African white woman is 71 years, but it is only 47 years for the South African black woman. The life expectancy for the white man in South Africa is 61 years; for the black man, it is 41 years. Thus, there remains much to be done.

HEALTH INSURANCE

There are approximately 30 million persons in America without health care insurance. The low income and uninsured experience greater difficulty[13–16] in obtaining physician care, are less likely to be hospitalized, and bear a higher burden of complex illnesses. Many of these individuals are hard working, well-motivated persons who serve as maids, barbers, house painters, small business owners, and workers who labor for a wage that is just above the minimum and who do not have hospitalization insurance as a fringe benefit.[14] As health care becomes increasingly more expensive[15] and business and government demand more and more for their dollar, this can only mean that the uninsured can expect to find it even more difficult to get health and hospitalization insurance and to gain access to health care.

Grady Memorial Hospital showed an increase in outpatient visits for 1986 over 1985 of 3.1 percent, with a total of 844,363 outpatient visits. Admissions increased by 2.8 percent for the year 1986 over 1985, with a total of 46,000 admissions. The number of admissions and outpatient visits for the calendar year 1986 was larger than any previous year in the history of this institution. Thus, in this instance, there are ever-growing numbers of people who are without health care insurance or who feel that their health care insurance is not adequate to protect their financial reserves.

Financial considerations are a significant factor, affecting the patient's decision as to whether private care can be sought. On the other hand, the excellent medical care rendered for well over a half century by the faculty and residents of Emory University School of Medicine is a major factor in the confidence of patients in metropolitan Atlanta, such that a number of patients seek care at Grady Hospital when they could afford to go elsewhere. In 1984, the Morehouse faculty began as members of the Grady active medical staff and are contributing high-quality medical care to Grady patients. Although there are some delays in seeing patients, Grady patients realize that they receive medical care in the vanguard of medical knowledge.

In the United States we spend approximately 11 percent of our gross national product on health care, while the United Kingdom only spends 6.5 percent of its gross national product on health care. Yet, the United Kingdom has health care for all its citizens that is free of charge at the time of service. The United States has approximately 31 million people without hospitalization and health insurance. Everyone (even low-income people) should pay something, no matter how small, for their health care. The reduced scale for low-income people should be such that they are not deprived of good nutrition, heat, light, transportation, and reasonable pleasures while on their low income. Perhaps the age for Medicare coverage could be lowered, and Medicaid could be extended to cover all persons based on income. The existing gap must be closed so that all persons in our nation have adequate health insurance. Just as Monty worked successfully for the National Medical Association to approve Medicare, we of today must ensure that all persons have adequate health care insurance.

A catastrophic hospital bill is defined frequently as one that exceeds 10 percent of the family yearly income.[17] Therefore, a modest hospital bill of $2,000 to $3,000 can be quite catastrophic for a low-income family. Unfortunately, children comprise a large segment of the uninsured. One third of all uninsured persons under the age of 65 years are children, despite the existence of Medicaid. Some reasons for the large number of uninsured children are that (1) parents do not have health insurance, and (2) the employer may purchase insurance for the employee, but not for employee dependents. Medicaid does not yet cover all the needy children. Any solution, therefore, to the catastrophic-illness problem must address the problem of the need for adequate health insurance for children and nonelderly adults.

Health care in the United States is primarily a fee-for-service system, which is just excellent for those who can afford it. The 30 million people in our nation without health insurance do have access to the health care system. All can obtain health care, but delays occur among those without health insurance, and they may eventually find themselves in the throes of a catastrophic medical event. Findings suggest that survival rates are poorer for the economically disadvantaged groups in general, irrespective of race. Low-income nonwhites have a higher cancer mortality rate than high-income nonwhites. With identical low-income levels, low-in-

come blacks have a higher cancer mortality rate than do low-income whites—the difference may be in education.

Low-income people must be targeted for increased health education and easier access to health facilities for prevention and treatment. Approximately 87 to 90 percent of the US population is covered by some form of health insurance. The uninsured population consists of white as well as minority citizens. The median income of black families in 1981 was $13,270, the nonminority median family income was $10,000 higher per year.

HOMICIDES

In 1980, the homicide rate for black men was 71.9 per 100,000 population, and 10.9 per 100,000 population for white men. The black homicide rate for those aged under 45 years is almost seven times that of whites, and, in 1983, black persons accounted for 43 percent of homicide victims even though their percentage of the population was only about 11.5 percent. Fifty-seven percent of homicides are committed by relatives or acquaintances, 15 percent by strangers, and 28 percent unidentified.[18] Ninety-four percent of black victims were slain by black assailants, and 88 percent of white victims were slain by white assailants.

Tragically, homicide rates do not give the true and total picture of the attack rates of blacks against blacks or whites against whites, for surgeons protect the lives of over 80 percent of the victims of traumatic attack. Accordingly, the ability of people to settle their disputes without a determined physical effort to maim or kill must be increased immensely in all ethnic groups, especially Afro-Americans. People must be taught, especially the young, that when they note a discussion beginning to degenerate into an argument, the best solution is simply to walk away, in dignity.

THE ENEMY WITHIN

The NAACP and the National Urban League are emphasizing the "enemy within"[4] in such areas as illegitimate births, drug addiction, illiteracy, crime, and a host of other problems that afflict black citizens disproportionately. Our schools, radio, television, billboards, and other resources must be better used to reach minority people in greater numbers for education. Teaching values would be of immense aid in health education, behavior, respect, and regard for women. A litany of statistics helps to emphasize the need for self-improvement.

In Georgia infant mortality, due largely to premature births by adolescent mothers,[8] for black babies is twice that of white babies throughout the nation. There are 44.4 premature births per 1,000 teenage pregnancies among whites and 69.5 per 1,000 among blacks.

A person earning an hourly wage of $5.00, which is above the minimum wage, would have to work for approximately four days to pay for an office examination that included a physical examination, urinalysis, blood count, SMA-18, chest roentgenogram, and electrocardiogram. Obviously, without health insurance such medical charges would be difficult to manage for even a savings-oriented, hard-working person. Seventeen percent of all Georgians live below the federal poverty standard; however, less than one third of the Georgians that are living in poverty are covered under Medicaid, as of 1984. Total expenditures[18] by Medicaid in Georgia for 1986 were $785,486,760, of which $76,738,936 was paid to physicians. Administration expenses totaled $29,646,502. Even though Medicaid expenditures are large, we must seek a means of total health insurance for all individuals.

In the early 1960s, fewer than 3 percent of all medical students were black, but by 1974, 7.5 percent were of this racial group. The ideal goal of 12 percent for Afro-American medical students was never reached. The highest percentage was in 1975,[10] a peak of 7.5 percent, which dropped to 5.9 percent in 1986–87. It is significant that minority applicants to medical schools are three times more likely to come from families with an annual income under $15,000 than are their majority counterparts. Accordingly, no- or low-interest loans and grants are essential for low-income people, especially for minorities. Other special programs, such as the military and payback programs and the concept of the National Health Services Corps, are important for minorities. Preparation for study in medical school really begins in kindergarten. More students need further instruction in the sciences, English, and mathematics; only 23 percent of black students[19] who graduated from high school in 1982 had three years of science, compared with 45 percent of Asian-Americans, and 34 percent of white Americans and Hispanics. Enrichment programs for minorities must continue so as to improve the educational experience of minorities at the high school level.

Carcinoma of the esophagus is ten times[19] higher in blacks than in whites; diabetes is 33 percent higher in the black population than in the white population, and diabetes in black women is 50 percent higher than in the white female population, and is largely related to obesity in the black female population.[19,20] Coronary disease, chest pain, and the fre-

quency of coronary bypass surgery are areas that black cardiothoracic surgeons are addressing; the frequency of cardiac catheterization and coronary bypass surgery is less in the Afro-American minority group.

The rate of drug abuse, as measured by cirrhosis of the liver caused by alcohol, is 30.6 per 100,000 black[19] men, and 15.7 per 100,000 white men.

In 1984, the four largest[21] for-profit hospital chains, namely, Hospital Corporation of America, American Medical International, Humana, and National American Enterprises, owned 709 hospitals with 105,000 beds. For-profit chains are generally not willing to provide adequate hospital services to the poor. Usually, the loss of public hospitals and the growth of for-profit chains means higher hospital costs for the entire community. For inner-city indigents who are poor and less able to afford health care from private hospitals, the closure or relocation of the public hospital means only one thing—less hospital care.[22]

In conclusion, one would be remiss if the problem of acquired immunodeficiency syndrome (AIDS) was not mentioned.[23–26] The black and Hispanic population accounts for 38 percent of the AIDS cases among adults, 73 percent of the AIDS cases among women, and 80 percent of the AIDS cases among children, while the percentage of the population of blacks and Latinos throughout the nation[23] is in the vicinity of 12 and 6.4 percent, respectively. The black population shares about 25 percent of the cases of AIDS.

Of the 36,514 cases of AIDS throughout the nation, approximately 9,043 cases involved black people, and about 5,143 cases, or 14 percent, involved Hispanic people. It is estimated that there are approximately 1.5 million persons in the nation who are HIV positive. Seven million dollars have been provided for the education of minorities in the prevention of AIDS.

The knowledge is available to markedly decrease the frequency of this illness, and we must target minority populations throughout the nation with intensity so as to gain control of the spread of this tragic disease. Sex education in the schools is progressing well in most areas and, again, the news media of all types must actively engage in a preventive public-health campaign against this tragic illness.

Literature Cited

1. Future Looks Bleak for Black Hospitals. American Medical News, April 10, 1987, pp 1, 42.
2. South African MD survives jailing and decries the effects of Apartheid. American Medical News, June 5, 1987, pp 2, 52.
3. Sullivan LW. Morehouse School of Medicine 'Tablet(s),' 1982–1987.
4. Tucker C. NAACP sets agenda that snatches itself back from the brink of irrelevancy. The Atlanta Constitution, July 15, 1987.
5. Georgia Hospital Association. State Health Planning Agency, November, 1986.
6. Cancer Facts and Figures, 1986. New York: American Cancer Society, 1986, pp 1–24.
7. Freeman HP. Cancer in the Economically Disadvantaged: A Special Report. Prepared by the subcommittee on cancer in the economically disadvantaged. New York: American Cancer Society, 1986.
8. Fulton County Health Department Statistics. Fulton County, Georgia, 1985, 1987.
9. Knutsen P, Petrek A. Early and late detection of cancer in metropolitan Atlanta. J Med Assoc GA 1981; 70:753–755.
10. Cureton MT, Prieto DO, Johnson LM. Minority Students in Medical Education: Facts and Figures III. Washington, DC: The Association of American Medical Colleges, Office of Minority Affairs, 1987.
11. Wharton CR, Jr. Leadership in medical education: The challenge of diversity. J Med Educ 1987; 86–94.
12. Freeman HP, Bernard L, Matory WE, et al. Physician manpower needs of the nation: Position paper of the surgical section of the National Medical Association. J Natl Med Assoc 1982; 74:617–619.
13. Freeman HE, Blendon RJ, Aiken LH, et al. Americans report on their access to health care. Health Affairs 1987; pp 1–6.
14. Wilensky FR. Viable strategies for dealing with the uninsured. Health Affairs 1987; pp 34–46.
15. Reinhardt UE. Commentary: Health insurance for the nation's poor. Health Affairs 1987; pp 101–112.
16. McCormick B. Opportunities and Marketing. American Hospital Association News, June 8, 1987, pp 3–6.
17. Report of the Secretary's Task Force on Black and Minority Health. Vol. I, Executive Summary. US Department of Health and Human Services. Government Printing Office, 1985.
18. Georgia Department of Medical Assistance Annual Report. 1986, 1987.
19. Health Status of Minorities, Special Report, No. I. Princeton, NJ: The Robert Wood Johnson Foundation, 1987.
20. Health Status of Minorities, Special Report, No. II. Princeton, NJ: The Robert Wood Johnson Foundation, 1987.
21. Rice MF. The literature and inner-city hospital closures/relocations: Signals for declining health care to minority and poor individuals. 114th Annual Meeting of the American Public Health Association, September 30, 1986.
22. Health Status of the Disadvantaged: Chartbook 1986. US Department of Health and Human Services. Government Printing Office, 1986.
23. Centers for Disease Control. AIDS Weekly Surveillance Report. Atlanta, June 8, 1987.
24. Surgeon General's Report on Acquired Immune Deficiency Syndrome. US Department of Health and Human Services, Government Printing Office, 1987.
25. AIDS in Minority Populations in the United States. Department of Health and Human Services Office of Minority Health. Government Printing Office, 1987.
26. Yancey, AG, Sr. The challenge of providing health care for the poor: Public hospital perspective. J Natl Med Assoc 1987; 79:107–111.