The Civil Rights Doctor, Revisited

Fitzhugh Mullan, MD

F. Mullan, deceased, was codirector, Fitzhugh Mullan Institute for Health Workforce Equity, and professor of health policy and management, Department of Health Policy and Management, George Washington University Milken Institute School of Public Health, and professor of pediatrics, George Washington University School of Medicine & Health Sciences, Washington, DC.

Correspondence should be addressed to Candice Chen, George Washington University, 2175 K St. NW, Ste. 250, Washington, DC 20037; email: cpchen@gwu.edu; Twitter: @GW_Workforce.

Editor’s note: On November 29, 2019, we lost one of the great voices of medicine of my generation with the passing of Dr. Fitzhugh Mullan. He wore many hats as a physician: pediatrician, health advocate, writer, teacher, researcher, and health administrator. I had the great privilege of working with him on many projects during his lifetime, but when he approached me about publishing this article, which is based upon a commencement address he gave, I was at first hesitant, because speeches often do not translate well into articles. But as I read it, I could sense that his article was far more than a commencement address—it was a call to action for social justice and a reflection on his remarkable life and its meaning. We at Academic Medicine are honored that he chose this journal to publish his last article, which I believe will be an important part of the legacy of his life as well as a call to future generations of physicians and other health professionals to walk in his broad and deep his footsteps along a journey whose end he could glimpse but sadly could not finish. —David P. Sklar, MD
Funding/Support: None reported.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

Previous presentations: This Invited Commentary is adapted from a commencement address delivered by the author at Yale School of Medicine, May 2018.
Abstract

The author recalls the summer of 1965, which he spent in Holmes County, Mississippi, as a medical civil rights worker. The poverty, bravery, ignorance, brotherhood, racism, hate, and love he experienced that summer led him to conclude he would become a civil rights doctor. When he returned to medical school in Chicago, the author and his classmates began organizing students around the idea of social justice. They intended to take on society’s big problems even as their medical education ignored them.

More than 50 years later, the author reflects on the sense of mission that attracts many people to medicine. A mission more than the desire to heal. A mission to recognize and address the inequities in the world and, more to the point, in access to health and health care. Medical schools have a unique role or “social mission” in that they are the only institutions that can build doctors for the future. The culture of the medical school is a powerful influence on the values of its graduates and, ultimately, the physicians of the country. The articulated, cerebrated, strategized mission that a medical school selects for itself has an enormous influence on who gets to be a doctor and what the values of that doctor are in the future, and that is why, the author argues, medical schools must incorporate social mission.

To achieve this vision, medical education must move beyond Abraham Flexner’s 20th century legacy. This is not to disown Flexner, science, or research but to re-think medical education based on the equity challenges that confront our population now. Physicians and the institutions that train them need to see social mission as a living part of the medical skill set rather than an elective perspective exercised by some who are particularly compassionate.
I spent the summer of 1965 in Holmes County, Mississippi. I had just finished my first year of medical school and went south as a medical civil rights worker. I lived on a small, poor farm that belonged to Magnolia Reed and her 17-year-old son, Cat. My work was to do whatever I could about local health problems and pitch in with the larger agenda of civil rights work going on across the state. I spent time going door-to-door to urge folks to register to vote and encourage parents to sign up their grade-schoolers to attend the white school that was to be integrated in the fall. I convened a health association—a chat group/organizing cell—in Durant, the nearby town, and paid testy visits to the town’s 3 general practitioners and to the administrator of the local 25-bed, segregated hospital. I spent half a dozen nights with a shotgun on my lap, smoking cigarettes, taking my turn guarding a rural, black church that had been the target of an earlier firebomb. The black community had decided to defend it.

It was a historic summer for the United States. Not only was the civil rights movement in full swing, but that same summer the U.S. Congress passed 2 pieces of legislation that were to have huge impact on civil rights and on health—the Voting Rights Act of 1965 and Titles XVIII and XIX of the Social Security Act, which established the Medicare and Medicaid programs.

It was a momentous summer for me. I suddenly knew why I was in medical school. The son and grandson of physicians, I had gone to medical school with a general idea of doing something good but no real sense of what that was. I had been raised in comfort and had seen little of the world and the disparities in wealth and health that are the American reality and the global norm. The poverty, bravery, ignorance, brotherhood, racism, hate, and love I lived with for those short months called out to me. When I headed back to school in the fall, I knew what I wanted to be. I wanted to be a civil rights doctor, a doctor for the people of Holmes County and others like them.
There was plenty to be done right away. When I returned north to the University of Chicago, it was to a medical school riven by inequities much like those in Mississippi, if less blatant. Out of the 72 students in my class, 1 was black—and he came from Nigeria. The obstetrics clinics in the hospital were divided by paying and non-paying patients, effectively providing racial segregation. The main function of the Student American Medical Association was organizing dances and running a microscope exchange. The American Medical Association itself was engaged in a last-ditch fight to block Medicare. A student did not have to be a radical to conclude that medical school was preparing us for the past and not the future.

We responded by organizing students around the idea of social justice. We started a student-run lecture series bringing speakers to the medical school to talk about health in Chicago’s ghettos, racism in medicine, and the war in Vietnam. We got the dean of Harvard Medical School to talk about medical education reform. We raised $200,000 to run a summer project that placed 100 medical, nursing, and dental students in service-learning projects in community organizations around the city. We built the Student Health Organization—a national alliance of activist groups in medicine, nursing, dentistry, and social work. We marched with Dr. Martin Luther King, Jr. who, in 1967, was campaigning to end segregation in Chicago’s suburbs. We intended to take on society’s big problems even as our education ignored them.

**Social Mission in Medicine**

That all happened more than 50 years ago but reflecting on those medical student experiences now raises an important question, as it did then: Why do we become doctors? We know that medicine will guarantee us a good living but, for many of us, the choice of medicine goes well beyond that. Idealism draws us—the opportunity of helping others, alleviating pain, extending life, and perhaps contributing new knowledge to human biology and clinical care. For a lot of
people attracted to medicine there is something more—a sense of what I will call “social mission” that is more than the desire to heal. Social mission recognizes that there are inequities in the world and, more to the point, in access to health and health care. In ways articulate and inarticulate, many young men and women entering medicine want to help in this regard. They hope to make the world not only a better place, but also a fairer place. This is social mission. Graduating competent doctors must be a school’s bedrock concern. Most today would also agree that it is important to go beyond technical proficiency by producing doctors who are compassionate, patient-centered, and good communicators. But what about graduating doctors who want to change the world by making it more just? Should this be a priority of medical schools in their selection and education of the next generation of physicians? Should the school concern itself with health disparities and the social determinants of health in its community, in the country, in the world? Should the school worry about equity of opportunity for disadvantaged students to study medicine? Should it be troubled about gaps in rural health or geriatric care? Should it be concerned that the United States has one physician for every 400 of its citizens while Malawi has one doctor for 100,000 people?1 Simply put, should medical schools have a social mission?

Medical schools and the universities in which they reside are custodians of intellectual and professional development in our society. They are, by their nature, idealistic institutions. To that end, our society generously rewards them with education and research funding and substantial tax benefits. They are public institutions. Medical schools have a unique role to play in that they are the only institutions that can build doctors for our future. I use the word “build” because their role includes but goes beyond education. Medical schools select our future doctors and nurture them for at least 4 years. During that time, they teach them medicine, but they also mentor, mold,
and motivate them. The culture of the medical school is a powerful influence on the values of its graduates and, ultimately, the physicians of the country. The articulated, cerebrated, strategized mission that a medical school selects for itself has an enormous influence on who gets to be a doctor and what the values of that doctor are in the future. We know, also, from published studies that social mission outcomes vary considerably among schools, with some graduating high numbers into challenging practice settings while others continue to send more physicians to well-endowed specialties and localities.2,3

Abraham Flexner’s Medical Education Legacy of the 20th Century

These observations have a firm historical root. The most important single document ever written on U.S. medical education was published in 1910 under the title, *An Examination of the Medical Schools of the United States and Canada*; today it is better known as the Flexner Report. Abraham Flexner was a distinguished educator appointed by the Carnegie Foundation to study the medical schools of the time. What he found and reported in 1910 was dismaying. The clear majority of the 155 schools he visited were of terrible quality, largely commercial, and graduating “ignorant men.” Flexner’s proposed solution was that medical education should be limited to “research universities” that were, increasingly, the beneficiaries of European science and scientific methods. Science offered a quality control mechanism against commercialism, opportunism, and charlatanism in medical education. The Flexner report succeeded brilliantly in ransoming medical education from commercialism and bad science. Within 20 years, more than half the schools in the country were shuttered, and virtually all that survived Flexner were sponsored by universities.
Medical education proceeded as a university-based enterprise rooted increasingly in academic health centers for which research and service delivery, as opposed to education, steadily became larger enterprises. The Flexner Report effectively guaranteed that medical education would become increasingly expensive and elite. Its emphasis on science, important as it was, promoted technical accomplishment over cognitive and communicative capabilities in practice and in scholarship. It bound medical education up in battleship institutions whose complex missions often did not prioritize the health of their communities or regions.

We live in a world more than 100 years removed from Mr. Flexner’s Report where, despite horrible events along the way, social justice has actually prospered. Since Flexner, the world has lived with, and now largely rejected, colonialism, apartheid, Jim Crow, and Nazism; in more and more of the world, women can vote, be educated, own property, and run companies and countries. Homophobia, female infanticide, and genocide are in retreat. We now dare to talk about health care as a human right. We have tools to measure health disparities, the social determinants of health, and Disability Adjusted Life Years. Health equity is a vital and viable idea.

The question confronting U.S. medical education now is how to move beyond the medical education legacy of the 20th century. This is not to disown Flexner, science, or research but to re-think medical education based on the equity challenges that confront our population now. In 2019, the United States is not compromised by quack medical schools. Nor is it suffering from a lack of research. Perhaps we have not yet “conquered” cancer or found the vaccine for AIDS, but we have created a dazzling clinical armamentarium—some of which is precise and well used, some of which is not. The proliferation of drugs, devices, and diagnostic tools we have invented
is enormously costly, our system produces disappointing results when compared to other
developed nations, and we still fail to provide health coverage for all our population.

We need doctors who understand these problems and are committed to fixing them. The call for
incorporating social mission is by no means limited to primary care or to those who see
themselves as activists. We need physicians of all specialties to work in rural areas and to treat
poor and low-income populations. We need physician research scientists and policy leaders
equipped to tackle these equity problems. We need the hospital chief medical officer who opens
a disparities solutions center that turns hospital-wide attention to inequities within the
institution. We need the anesthesiologist who is concerned about differential patterns of pain
management in her institution that seem to fall along racial lines for no good or stated
reason. We need medical school deans who will make it a personal priority to see to it that
graduates of their local, inner city high schools are entering their medical school class 4 years
later. Physicians and the institutions that train them need to see social mission as a living part of
the medical skillset rather than an elective perspective exercised by some who are particularly
compassionate.

**Looking Ahead**

How did the career of the “civil rights doctor” work out? Has the world changed as he had
hoped?

In many ways, yes. Integration has proceeded; opportunities for minorities in the United States
are much improved, as is the economic well-being of many. In medicine, 16% of our students
are underrepresented minorities\(^5\) as opposed to 3% in the 1960s.\(^6\) But in many ways, no, things
have not gone as he had hoped. African Americans, Latino-Americans, and Native Americans
comprise 33% of our population\(^7\) meaning that our efforts at opening opportunities in medicine
have only reached a halfway point. Residential and educational segregation remain in place everywhere. Huge disparities in income, net wealth, opportunity and longevity are the rule for minorities and the poor of all ethnicities. The civil rights doctor and many others have spent careers in pursuit of what we now call health equity, but the world has not moved as far as he would have wanted. Racism is still very much with us, as are massive and growing disparities in health and wealth. These disheartening realities account for tens of thousands of deaths and uncounted days of unnecessary pain and suffering every year.

The civil rights doctor’s mission turned out to be changing the culture of medicine, making the idea of health equity central to the character of medicine, and positioning medicine as an agent of social as well as individual healing. Choices physicians make about where and how to practice can bring more compassion to the system but, ultimately, it is the U.S. medical education community that can do the most. Large, resourceful, and distributed, the nation’s medical schools and teaching hospitals have early and strong leverage to change the culture of medicine. The civil rights doctor may have worked hard and with purpose but it is only with a forceful, enduring, and community-wide commitment to social mission that medical education will realize its full 21st century capabilities to build a healing profession.
References


