

Abraham Flexner and the Black Medical Schools

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In 1900, a black student wishing to pursue a career in medicine could choose from 10 schools in a variety of locations and settings (Table 1). By 1920, a black student had only three choices and little assurance that any one of these schools would survive until graduation day four years hence. What had happened? The Flexner Report, containing devastating comments about all but two of the black schools and demeaning statements about black physicians, appeared in 1910, directly affecting the fate of these schools. By 1923, only the two institutions he said deserved to exist, Meharry Medical College and Howard University Medical Department, remained. Those two schools, too, almost closed their doors as organized medicine and medical philanthropies pushed the educational reforms promoted by Flexner beyond the capacities of the black institutions to change. Between 1905 and 1920, black medical education passed through two crisis periods: 1905-1912 and 1917-1918. Flexner was involved in both.

The Condition of Black Medical Schools in the Early 20th Century

Contemporaries classified black medical schools according to their origins as either missionary or proprietary. Though some institutions in the north accepted a few blacks as medical students, no state, north or south, operated a medical school for African Americans. In addition to establishing many colleges to educate freedmen after the Civil War, northern religious groups founded a small number of medical schools. For example, the Freedmen's Aid Society of the Methodist Episcopal Church oversaw the development of Meharry Medical College and Flint Medical School, and the American Baptist Home Mission Society allowed Shaw University to operate Leonard Medical School. Howard University and its medical department had Congressional backing but also received financial support from individual, nonsectarian donors. The proprietary schools, founded in every case by black physicians, had little if any outside funding.

The precarious nature of these schools' financial arrangements, whether overseen by white missionary groups or by enterprising independent black physician proprietors, put all the African-American medical colleges in a vulnerable position from the start. Most of the schools collapsed with the increased pressure for reform in the first decades of the 20th century. Meharry, Howard, Leonard, Flint, Knoxville and Louisville National were still struggling to survive and improve when American medicine "discovered" bacteriology, laboratories, public health and the German education system. With the revitalization of the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC) at the turn of the century and these organizations' relentless application of pressure to improve medical education based on the new ideas in science and education, African-American medical schools found themselves caught in a paradoxical situation. On the one hand, they saw the demand for their product—the MD degree—growing to the point at which some of them could not accommodate all applicants. In 1907, for example, President Charles F. Meserve of Leonard Medical School told Wallace But-

trick of the General Education Board (GEB), a Rockefeller family philanthropy, that his school had more applicants than places in each class and more requests from towns for black physicians than graduates each year.¹ On the other hand, every black medical school faced mounting financial pressures as the demand for better-trained professors, a longer school year, well-equipped laboratories and clinical facilities drained limited resources.

The proprietary schools had no sources of income other than student fees and perhaps a small investor or two. Theoretically, the missionary schools could raise funds from other parts of their universities, their home mission societies or religious sect donors in the north. In actuality, black colleges raised little excess funding to shunt into medical education, and northern mission societies and individual donors were at this time shifting priorities to such newer, more immediate problems as helping the large numbers of eastern and southern European immigrants who were moving into their cities. Moreover, black students generally came from poor families that could barely pay even the low tuition, fees and living expenses of medical college, so the schools could expect little extra cash from that source. Few black physicians had succeeded well enough by the early 20th century to support their alma maters, nor were black philanthropists able to do so.² State universities offered little for black students desiring a medical education. The rising demand for black physicians and limited fundraising opportunities caused problems for

black medical schools at a time when they wished to encourage growth and modernization.

Pressures for Change before Flexner

As historians have shown, Abraham Flexner did not inaugurate American medical education reform with his 1910 report;³ he stepped into the middle of such an era, put his imprint on it and, through his work with the GEB after 1912, influenced the way reforms were implemented. When Flexner began working for The Carnegie Foundation for the Advancement of Teaching in 1908, the AMA's Council on Medical Education (CME) had already evaluated the nation's medical schools three times, twice using state medical licensing board results and once through personal visits. Arthur Dean Bevan, MD (chair) and N.P. Colwell, MD (secretary) had published in the *Journal of the American Medical Association (JAMA)* the failure rates of individual schools on state licensure board examinations and even a listing of acceptable medical colleges based on a classification scheme they implemented.⁴ Though they did not publicize the reports stemming from their site visits, Bevan and Colwell sent these reports to the schools and to the state medical examining boards, hoping to spur improvements at the poorer-rated institutions. The African-American schools fared badly in these evaluations. Their board failure rates in 1904 and 1905 all greatly exceeded 20%—the worst category⁵—and when the two years' scores were combined, each of the six schools with sufficient available data appeared in the

Table 1. Black medical colleges, 1868–1923

Name	City	Year Opened	Year Discontinued	Affiliation
Howard University Medical Dept.	Washington, DC	1868	–	None
Lincoln University Medical Dept.	Oxford, PA	1870	1874	Presbyterian (local)
Straight University Medical Dept.	New Orleans	1873	1874	American Missionary Assn.
Meharry Medical College	Nashville	1876	–	Methodist Episcopal Baptist
Leonard Medical School of Shaw Univ.	Raleigh	1882	1918	Independent
Louisville National Medical College	Louisville	1888	1912	Methodist Episcopal
Flint Medical College of New Orleans Univ.	New Orleans	1889	1911	Independent
Hannibal Med. College	Memphis	1889	1896	Independent
Knoxville College Medical Dept.	Knoxville	1895	1900	Presbyterian
Chattanooga National Medical College	Chattanooga	1899	1904	Independent
State University Medical Dept.	Louisville	1899	1903 Merged with LNMCC	Colored Baptist (Kentucky)
Knoxville Medical College	Knoxville	1900	1910	Independent
University of West Tennessee College of Medicine and Surgery	Jackson	1900	1907	Independent
	Memphis	1907	1923	
Medico-Chirurgical and Theological College of Christ's Institution	Baltimore	1900	1908?	Independent

bottom 30% of the 135 studied.⁶

After its establishment in 1904, well before Flexner's arrival, the CME promoted both higher entrance requirements and higher educational standards, making its appeals both to schools and to state regulatory boards.⁷ Most black schools responded by lengthening their terms, improving hospital and laboratory facilities, and, at least in written documents, toughening entrance and graduation requirements.⁸

The CME had also noted, before Flexner, the cost to medical schools of needed changes and the necessity of obtaining outside funding for these reforms. A *JAMA* editorial in May 1907 announced that modern medical education now required two or three times the amount received in fees from each medical student. Proprietary schools, the editorial continued, simply did not possess the ability to raise and pay out such amounts; a large endowment from private sources or state support was needed to sustain a school. Medical education was changing for the better, it concluded, but too many schools lagged behind, unable to keep up with the rising standards.⁹ At annual conferences on medical education, the CME began doing more than simply publicizing poor board scores and urging schools to improve; it proposed guidelines for an acceptable education program and wrote a model state medical practice act.¹⁰

So the CME's efforts before Flexner, though not directed specifically at black medical schools, in effect put them on notice. Administrators at African-American institutions understood the message and realized that the expense of change as well as the changes themselves threatened each school's existence. In June 1906, the CME sent a letter to every American medical school, urging adoption of its proposal that all students take at least one year of college-level work in biology, chemistry, physics and a foreign language before admission.¹¹ Acceptance of this plan would have immediately reduced the number of students at black medical schools, because few young African Americans went to college before starting their professional education. Furthermore, only a few African-American colleges offered such advanced courses, and only a handful of white colleges admitted black students. Reduced enrollments at black medical schools would have meant reduced income, a situation these schools had to avoid, for both missionary and proprietary schools relied on student fees as the major source of funds. Not surprisingly, then, none of the African-American medical colleges responded positively to the AMA's request, though each year the number of white schools implementing the plan grew, as did the pressure for black schools to follow suit.¹²

The CME presented other reform ideas during these pre-Flexner years that threatened the black schools in particular. Bevan, for instance, must have upset authorities at black schools with his comments about instructors, made at the April 1907 annual CME conference in Chicago. He alluded to some medical schools conduct-

ed by people respected in the profession, but imparting information and teaching the techniques of a former era. These institutions offered students little practical experience in the laboratory, the hospital ward or the clinic, instead lecturing and quizzing them in the classroom.¹³ Though catalogs of African-American medical schools claimed to train modern physicians using modern techniques, other available information belies those statements. Leonard's faculty at this time, for instance, differed little from the faculty 25 years earlier, shortly after its opening. These local white practitioners, some highly respected in Raleigh, NC and around the state, had trained early in the modern medical period. Some had not kept up with the new scientific ideas and educational innovations. With a tiny hospital open only during the school year and few laboratory facilities, Leonard could not really offer the best medical education to its students.¹⁴ At Flint and Meharry, both supported in part by the Freedmen's Aid Society, many members of the predominantly black faculty were either recent medical graduates (usually of Meharry) with little practical experience or graduates of many years ago who, because of race restrictions, had not attended postgraduate courses. Faculty at the black proprietary schools consisted primarily of their own graduates, some just a year or two out of school.¹⁵

Bevan also attacked "medical schools conducted solely for profit" in his April 1907 address, calling them "a menace" and advocating their nonrecognition. Though the black proprietary schools had their failings, they seem not to have existed "solely for profit" and did turn out needed black practitioners. But the CME pressed hard to eliminate all proprietary schools and thereby put pressure on those run by and for blacks in this pre-Flexner period.¹⁶

Finally, Bevan spoke quite critically of schools offering courses after four o'clock in the afternoon, when students with full-time jobs were no doubt tired from a day's work and had insufficient time to fit in full-length courses with laboratory and ward work. The AMA House of Delegates instructed the CME just two months after Bevan's address not to rate higher than class C any medical college that offered evening courses.¹⁷ Howard University Medical Department was then still offering night courses in Washington, DC, where a strong demand for such a program existed.

So a year before Flexner even began his medical school survey, officials, faculty—and perhaps even students at African-American medical schools—felt pressure to change their institution's educational program. They could relate to their own colleges what Leonard president Meserve said of his: "A crisis has come in the life of Leonard Medical School." The school, he felt, had no future if he could not find sufficient financial aid to upgrade it to meet the new educational demands.¹⁸

By December 1908, when Flexner began his study of

medical education in the United States, three of the weakest (both financially and academically) black schools had closed their doors: the Medico-Chirurgical and Theological College of Christ's Institution in Baltimore, MD; State University Medical Department in Louisville, KY (merged with Louisville National Medical College); and Chattanooga (TN) National Medical College. Little is known about the first school; it apparently had no strong academic or financial basis and few graduates. The actual date of its closing is not clear, though it is not mentioned in AMA or AAMC records after 1908.¹⁹ State University, despite its name, had no affiliation with the Commonwealth of Kentucky, but received its support from the state's black Baptist organizations. The university continued to train undergraduates and ministers after joining with Louisville National Medical College in 1903, eventually becoming Simmons College.²⁰ Chattanooga National Medical College, named by its founder after his alma mater, Louisville National Medical College, graduated perhaps 16 students before closing during its sixth year, in 1904. Based on the small amount of evidence available, Chattanooga National Medical College's academic program, facilities, equipment and teaching staff appear inadequate.²¹ Three of the seven remaining black schools—the University of West Tennessee and Knoxville Medical College (both proprietary) and Leonard Medical School (Baptist)—received ratings of less than 50% from the CME in June 1908.²² The CME also recommended that state examining boards withdraw recognition from these institutions.²³

Flexner's Evaluation of Black Medical Education

African Americans seeking a medical education already faced challenges when Flexner completed and published his report in 1910.²⁴ The report: 1) announced the existence of black medical schools that turned out practicing black physicians, 2) described the good and bad points of these schools and advocated improvements or closings just as with the white schools, 3) reflected an outlook about black medical education that the AMA readily accepted and applied in its formulation of education policy, and 4) revealed negative white attitudes toward black physicians during an era of increasing racial tension.

Until the Flexner Report, organized medicine had said little directly to or about the black medical schools. Though the CME, almost from its establishment in 1904, had issued annual reports, articles and commentaries on medical education in *JAMA*, never in the 15 years of major medical education reform did *JAMA* ever openly discuss the issue of medical education for blacks. Women's medical education received a passing reference in each annual education issue and an occasional article. Black schools received no notice other

than the word "colored" posted next to their names in tables, and one-sentence statements when one of them received a gift, completed a building or closed. Even state medical journals of the period rarely acknowledged the presence of African-American schools within their state's borders.²⁵ The Flexner Report, describing each of the seven existing black institutions and spending fewer than two pages on black medical education problems, at least documented the almost invisible presence of African-American medical schools.

But the Flexner Report also harmed the black cause by portraying African-American medical education as deficient in general, and five of the seven black medical schools as particularly wanting. It said little good about the three proprietary schools—West Tennessee, Louisville National and Knoxville—or two of the missionary schools affiliated with universities—Flint and Leonard. It did praise the "small and scrupulously clean hospital of eight beds" at Louisville National.²⁶ But it also noted the "meager equipment for chemistry, pharmacy and microscopy" and the "bare ... rooms" at West Tennessee,²⁷ the absence of laboratory or clinical facilities at Knoxville²⁸ and the paucity of laboratory materials at Leonard²⁹ and Flint.³⁰ Flexner's criticisms were harsh ("The catalogue of this school [Knoxville] is a tissue of misrepresentations from cover to cover"),³¹ frank ("Of the three negro schools in the state [Tennessee], two are without merit"),³² chiding ("The school [Knoxville] occupies a floor above an undertaker's establishment"),³³ sarcastic ("It was stated by a student that twice between October 1 and January 28 'a few students were taken to the Knoxville College Hospital'"),³⁴ and biting ("Laboratory facilities [at Leonard] ... comprise ... a slight chemical laboratory, and a still slighter equipment for pathology").³⁵ Sometimes, he allowed the mere statement of facts without comment to convey his message: "The school [Flint] controls a hospital of 20 beds, with an average of 17 patients monthly and a dispensary with an average daily attendance of one or two";³⁶ "There is a dispensary [at West Tennessee], without records, in the school building."³⁷ Flexner's reports on these five schools told readers that black students, and by implication, current black practitioners who had graduated from these schools, did not receive an adequate medical education. He even stated at one point, "Of the seven medical schools for negroes in the United States, five are at this moment in no position to make any contribution of value to the solution of the [Negro health] problem above pointed out. They are wasting small sums annually and sending out undisciplined men, whose lack of real training is covered up by the imposing MD degree."³⁸

The report did more than describe poor conditions at black medical schools; it prescribed a limited role for black physicians in their practices and hinted that black physicians possessed less potential and ability than their

white counterparts. The tone of Chapter 14, “The Medical Education of the Negro,”³⁹ illustrated well how, in the world of medicine as in so many other aspects of American life at the time, whites attempted to discount, dominate and devalue blacks. It began with a provocative statement: “The medical care of the negro race will never be wholly left to negro physicians.” His second sentence explained this assertion by claiming that whites had to teach the black physician “to feel a sharp responsibility for the physical integrity of his people.” Black doctors, according to Flexner, lacked responsibility enough to take over full care of their own people, but white doctors possessed that sense. Furthermore, “The practice of the negro doctor will be limited to his own race.” Flexner’s reasoning for such comments became clearer as he next explained how educating black physicians would also serve white interests in preventing the spread of diseases from blacks to whites. He was clearly writing for a white audience when he concluded, “The negro must be educated not only for his sake, but for ours.” To protect the nation’s overall health, the responsibility of “educating the [black] race to know and to practice fundamental hygienic principles” fell naturally to the black doctor. Thus, “a well-taught negro sanitarian will be immensely useful.” So Flexner not only limited the role of African-American physicians to caring for other African Americans but further restricted it to matters of public health.

Where did black medical schools fit in Flexner’s scheme? They had two missions: 1) to offer “the more promising of the race ... a substantial education in which hygiene rather than surgery ... is strongly accentuated;” 2) to “imbue these men with the missionary spirit so that they will look upon the diploma as a commission to serve their people humbly and devotedly, away from large cities [in] the village and [on] the plantation, upon which light has hardly as yet begun to break.” If Flexner spelled out in more detail how to implement a program to accomplish these goals for black medical education, so different in many ways from the more research- and practice-oriented program for whites described in the rest of his report, he must have done so orally. None of his extant letters to the black medical schools or his published writing discussed these matters.

The two medical schools that Flexner believed to be suited for training black physicians were Meharry and Howard. He admired Meharry founder George W. Hubbard, MD’s skill at marshalling slender resources and building his school into a credible institution with good laboratory facilities and a small but well-managed endowment. Meharry lacked only a larger hospital and dispensary. Howard, with its ties to the federal government through a small annual appropriation and the use of Freedmen’s Hospital, had its future “assured.” Both schools, Flexner knew, needed “developing,” and both

were “unequal to the need and the opportunity” as they then existed. He urged religious and philanthropic organizations as well as individuals to concentrate their efforts on these two institutions and not to waste separate small amounts of money on the other five schools.⁴⁰ Flexner’s recommendation on medical education for African Americans in 1910 was to close the five “ineffectual” schools and encourage their supporters to donate time and money toward building Howard’s and Meharry’s programs.

The Influence of the Flexner Report

In the end, Flexner’s black medical school plan prevailed. Only Howard and Meharry survived the reform era, though both continued to train a full range of medical practitioners rather than “sanitarians” for rural African Americans. Of the five other institutions, three closed within two years of the report, one fought on doggedly for another eight years, and one proprietary school defiantly remained open until 1923, though its graduates were unrecognized by most state licensing boards. Knoxville Medical College, criticized severely by Flexner, closed the same year the report was published. The following year, Flint Medical College, sponsored by the same Freedmen’s Aid Society of the Methodist Episcopal Church that was supporting Meharry, shut down after 20 years. Flint’s president explained that the CME’s increasingly intense campaign for improved standards and the school’s lack of money to make the necessary changes forced its closing.⁴¹ Louisville National Medical College lost its accreditation from the Kentucky State Board of Health and closed in 1912.⁴² The influence of the Flexner Report can be seen in the demise of each of these schools.

Few if any African Americans responded directly to the report in writing, though physicians and educators must have discussed it. The Committee on Medical Education of the National Medical Association (NMA)—black counterpart to the AMA—had considered the problems of black medical schools in 1908 and 1909 after the publication of state board scores in *JAMA* but remained silent (at least in writing) on the Flexner Report and medical education in general after 1910. This committee had no power to implement education policy at black medical schools. It simply advised NMA officers and members of medical education matters and made recommendations for improvements. The committee had recognized the weaknesses of the several black colleges even before Flexner and wished to avoid public embarrassment over them. That, unfortunately, was no longer possible.⁴³

In 1912, the end of this first crisis period, only four black schools remained. One of these, the University of West Tennessee, was isolated from the others until it closed in 1923, its president taking an independent course.⁴⁴ Howard and Meharry, the two schools of which

Flexner spoke positively, seemed to have bright futures, leaving only Leonard to prove itself worthy and secure a firmer position.

The Flexner Report did not conclude an era of medical reform; it appeared in the midst of one. Medical education standards continued to change, to improve, pushed along by the schools themselves, the AMA, the AAMC, state licensing boards, and two major funding agencies—The Carnegie Foundation for the Advancement of Teaching and the GEB. The remaining African-American schools still faced difficult times. Howard and Meharry had received A ratings from the AMA in the second round of visits (the Flexner visits of 1909 to 1910), though in a special category called “Medical Schools for the Colored Race.”⁴⁵ They had to keep up with the latest innovations to retain their positions. Leonard, rated C, had to catch up.

The Flexner Report brought attention to seven black medical schools: their presence, their needs, their shortcomings and their potential. Three could not change sufficiently and closed. The remaining schools had to prove themselves. But no one in the white medical establishment, not even Flexner, who wanted Howard and Meharry to endure, helped the schools through this next crisis period until one more had closed and the other two were about to follow suit.

The Search for Funding

On February 21, 1910, Howard University President Wilbur Thirkield acknowledged receipt of an advance copy of Flexner’s assessment of his medical school: “We are deeply gratified by this favorable representation of the equipment and work of the school.” He told Henry S. Pritchett, PhD, president of The Carnegie Foundation, that Howard would immediately require of all its freshmen applicants one year of college-level science.⁴⁶ Three months later, Edward Balloch, medical dean, submitted his annual report to Thirkield, telling him of the faculty’s acceptance of the new admissions requirements but concern at the anticipated decline in enrollment and loss of revenue from student tuition. Because Howard relied on fees for most of its income, plus a small allowance from the federal government, Balloch knew that trouble lay ahead. Only by the extraordinary efforts of the school’s secretary-treasurer, the underpayment of faculty salaries and strict economy of educational expenditures did the medical department break even each year. Student fees just covered costs. But, Balloch continued, it was not fair to pay the faculty so little or to provide them with so few supplies and so little equipment. The medical department needed at least \$10,000 over tuition and fees the following year to pay for the cost of education. What Howard really needed was a half-million-dollar endowment. Securing one “should be given precedence over everything else.”⁴⁷

Within months, Thirkield wrote a letter to Andrew

Carnegie, reminding him of his expression of interest in Howard University Medical Department at the recent Carnegie Library dedication on campus.⁴⁸ Undeterred by Carnegie’s quick response that Howard was worthy, but that he had given them \$50,000 for the library the previous year and the government already provided annual financial support,⁴⁹ Thirkield held further discussions with Carnegie’s personal secretary. In May 1911, he submitted an ambitious proposal for \$200,000 to erect and equip a new building for the medical school. This time, he enclosed references from Dr. William Henry Welch of Johns Hopkins, Pritchett of The Carnegie Foundation, President William Howard Taft, and Dr. Woodward (PhD) of the Carnegie Institution, attesting to the value and importance of this investment. He included a fact sheet illustrating the school’s need for buildings, salaries for full-time professors and other budget items. Then, as President Meserve of Leonard Medical School had stated just a few years earlier in an appeal for funds, Thirkield explained that the Howard University Medical Department “has reached a crisis in its affairs.” “On the one hand, it is confronted with the necessity of providing medical education for colored students which shall comply with modern standards; on the other hand is the absolute impossibility of providing such education when the income is derived from fees alone.” Taking his cue from Flexner’s report, Thirkield informed Carnegie that Howard “trains men of science, especially versed in the problems of sanitation and preventive medicine.” The work of its graduates would improve white health as well as black because many diseases are transmitted from one race to the other.⁵⁰ Despite these appeals and others over the next few years, no dollars from the Carnegie fortune found their way to Howard’s medical school.⁵¹

Hubbard of Meharry also appealed to Carnegie, for \$20,000 to build a hospital. Flexner had urged its construction in 1910 to make Meharry a first-rate medical school. Carnegie agreed and donated \$10,000 on the condition that Hubbard raise the rest. This he did, and in 1913 the G.W. Hubbard Hospital was dedicated.⁵² But Meharry’s further appeals, like Howard’s, for larger sums or for an endowment, elicited similarly negative responses. Andrew Carnegie finally told Pritchett, who had urged funding, “If we start helping medical colleges for colored people, we cannot discontinue.” Their needs, he felt, were too great and their allies who might help in the funding too few.⁵³

The needs of black schools *were* great—too great for individual philanthropists or religious outreach boards, such as the Freedmen’s Aid Society (supporting Meharry) or the American Baptist Home Mission Society (supporting Leonard) to manage. Yet The Carnegie Foundation, the philanthropic organization associated with Flexner’s investigation that ultimately encouraged continuation of Meharry and Howard, refused financial

assistance to these schools. In 1912, Flexner himself moved to the other large, education-oriented philanthropic organization in the United States, the GEB. Black medical school officials wrote to both Flexner and Pritchett, hoping that the personnel change signaled a policy change as well, but both the GEB and The Carnegie Foundation turned them down or delayed action for several years.⁵⁴

A Second Crisis Period

Between 1912 and 1918, the situation worsened for the black schools. Leonard could not get the ear of any funding agency after the GEB gave it a tiny amount toward a new hospital in 1910.⁵⁵ In 1914, the school, despite its high admission standards and reasonably good laboratory facilities, of necessity dropped its clinical program in exchange for a B ranking from the CME.⁵⁶ Earlier that same year, Meharry lost its A rating and received a reprimand from the CME representative who visited the school. A number of problems had been identified: the faculty consisted of only three full-time and 24 part-time instructors for 354 medical students; the school's enforcement of student entrance standards could not be verified from existing records; medical, dental and pharmacy students took classes together; the new hospital, with 58 beds, had only 23 occupants at the time of the visit and averaged only 30; the outpatient department served only 6–8 patients per day; no medical library, medical museum or modern teaching tools such as reflectoscopes or stereopticons were available for student instruction; laboratories were poorly equipped; no course was offered in pharmacology; the curriculum was only partially graded—first- and second-year students took classes together as did third- and fourth-year students. To that time, the inspector stated in his report, Meharry had retained a class-A rating because it was a black school. After each previous inspection, investigators had told school authorities of existing problems and how to correct them. Many of the deficiencies could have been corrected at little expense. Because Howard University upheld proper entrance requirements (it had just begun insisting on two years of college courses) and offered a strong education program, the CME need not keep Meharry “in a classification where it clearly does not belong.” So the CME voted to reduce Meharry to a B ranking.⁵⁷ Medical education for African Americans seemed to be deteriorating.

The CME, in addition to rating schools, campaigned to tighten state licensure requirements. More and more states began insisting on basic college science courses,⁵⁸ or even two years of college, as entrance standards for their medical schools or as prerequisites to taking licensure exams. Some states even refused licenses to graduates of both white and black class-B and -C schools.⁵⁹

The black schools continued to appeal for help from Pritchett at The Carnegie Foundation and Flexner at the GEB. Neither man ignored the problem, but both found

their efforts thwarted or delayed by their own or other agencies. They tried to convince their respective boards to fund African-American medical education between 1912 and 1916, but neither foundation would be pushed too quickly.⁶⁰ Not until December of 1916 did the two agencies combine forces and offer Meharry, as a stopgap measure, \$15,000 a year so that it could remain open but still without an endowment.⁶¹ As Flexner observed Howard's and Meharry's struggles to maintain their programs, he worried that they (and all other medical schools in the South) ought not be pushed into radical changes too quickly lest they be forced to close unnecessarily. They should not, he believed, be compared to white northern schools, but rather should be permitted to make improvements based on a less compressed timetable. Flexner strongly disapproved of the CME's constant pressure on Meharry to improve. In late 1914, he feared that Meharry would “be choked” if the CME forced too many changes too quickly on the black schools. But the CME persisted in spite of Flexner's protests.⁶²

In fact, the black schools *were* being choked. They were caught in a power squeeze between, on the one hand, two large foundations that put white medical education needs above black, and on the other, a powerful medical organization that refused to recognize the special needs of African-American medical schools and African-American physicians. The crisis peaked in the fall of 1917. None of the three missionary black medical schools was healthy, and Leonard was about to collapse. Hubbard presented the problems of African-American medical schools to the annual meeting of the Southern Medical Association, which passed a resolution urging the AMA to take action to save the schools.⁶³ Aaron McDuffie Moore, MD, a Leonard graduate and respected Durham, NC, physician, headed a committee of the NMA that drew up and sent an eloquent and desperate “Appeal for Medical Education for Negroes” to the AMA, the GEB and The Carnegie Foundation.⁶⁴ Meharry and Leonard officials asked the CME for “reinspections” and A ratings, lest they lose recognition with the licensure boards of several southern states. The CME responded that it would happily reevaluate the schools but that, without endowments, Leonard and Meharry could not improve their education programs in any meaningful and permanent way. Nor could the CME compromise its standards for some schools without jeopardizing its own credibility. The problem was really out of its hands. State licensing boards and medical colleges themselves were increasing the pressure to raise standards.⁶⁵ Colwell, secretary of the CME, did personally appeal to Flexner and Pritchett to give endowments to the black schools, asserting that the GEB and The Carnegie Foundation were doing these colleges “a grave injustice” by withholding funds.⁶⁶ He had, on February 4, 1918, already made these statements publicly in an address to the CME conference of 1918, which was later published.⁶⁷ Flexner and Pritchett responded hotly and

frankly, asking Colwell to consider “how far this injustice is due to the action of the Council.” They felt the black schools were making “good progress under the normal pressure of improvement” and did not need CME’s harsh prodding.⁶⁸

By May 1918, Moore and others were desperate. Leonard faced imminent closing, and black doctors attending recent state association conventions were “very much depressed” over the situation there and at Meharry. Using words that illustrate the stature Flexner had achieved in medical education circles, Moore wrote to him,

We are making our final appeal to you as the most potent representative of the medical profession in America and also as the Financial Agent whose word is final on such matters. We regard your Board [GEB] as an equalizing agency,

because tax money in the south was spent on educating white physicians and none was spent on black medical education.⁶⁹ Flexner, however, deflected the arrow of blame back at the CME and Colwell. Accusations and denials again flew back and forth. Colwell labeled the situation a “so-called crisis,” claiming that recent actions by Florida, North Carolina and Virginia to deny recognition to class-B institutions had “suddenly awakened Meharry and Leonard to the importance of seeking a class-A rating—a rating which they have been content to do without for several years.”⁷⁰ Interestingly, in the midst of these battles over the fate of black medical schools, fought between organized white medicine and organized white philanthropy, the principal leaders on both sides found one point on which they agreed: that “high-grade white schools such as Columbia and the University of Pennsylvania” needed funding on a large scale before the black schools.⁷¹

In the end, no agency acted to save Leonard, which closed before the 1918–1919 school year began.⁷² The annual \$15,000 joint Carnegie Foundation/GEB appropriation kept Meharry alive for another year until the two foundations could finally agree on a \$300,000 grant, contingent on Meharry’s raising \$200,000 more.⁷³ Howard, the school with the most promise in 1910, staggered along without significant philanthropic funding until the early 1920s, as Pritchett and Flexner favored Meharry.⁷⁴ The first two decades of the 20th century ended with three black medical schools still open—the University of West Tennessee existing precariously as an unrecognized proprietary institution, and Meharry and Howard with small endowments—and none with an assured future.

Flexner worked closely on the problems of medical education for blacks from 1908, when he began his study for The Carnegie Foundation for the Advancement of Teaching and the AMA, through the next

decade. He believed only Howard and Meharry possessed the potential for success in the medical education system he envisioned and argued for their survival at the expense of the other five. Those five did close—three, it appears, as a direct result of his 1910 report, one (Leonard) despite his attempts to ease the CME’s pressure on it and one (West Tennessee) for other reasons. His strong efforts to provide funding for Meharry helped save that school from closing.

Black Medical Education to Mid-Century

From 1920 to 1950, the two remaining black medical schools continued their struggle for existence in the white medical world, one emerging stronger than the other. A black student entering either school during these years might still have wondered, as had students in 1900, whether the school would survive until graduation day. By the 1930s, though, Howard was in a less precarious position than Meharry. Organized medicine and large philanthropies continued to exert influence over the schools.

For Meharry in 1921, the first priority was obtaining an A rating from the CME. Flexner convinced a reluctant CME in 1922 to raise Meharry’s ranking after it had twice in two years refused to do so. But Meharry was still not, in the opinion of many, an A school. As one recent historian has characterized Meharry during this period, “laboratory facilities were grossly inadequate; instructors were overworked, poorly paid and under-trained; library resources were virtually nonexistent; and students were indiscriminately admitted.”⁷⁵ Meharry’s president, John J. Mallowney, Hubbard’s successor, mismanaged the institution and generated much ill will among faculty and staff and within Nashville’s black community. The GEB, under Flexner’s influence, poured millions of dollars into the school’s budget (about \$8 million between 1916 and 1949) and became involved between 1933 and 1938 in the movement to remove Mallowney as president and appoint Edward Turner of Chicago. Turner did much to improve the school in a short time, saving Meharry’s A rating in 1938. Money problems continued to plague the school throughout the 1940s. Announcements by the GEB and other philanthropists during that decade that they would soon cease making contributions to Meharry plunged the institution into another financial crisis at the dawn of the Civil Rights era.⁷⁶

Howard also faced financial problems between 1920 and 1950, but of a different sort. Because the U.S. Department of the Interior provided funds for Howard’s operating budget and allowed free teaching use of Freedmen’s Hospital, adjacent to campus, large philanthropic organizations, such as The Carnegie Foundation and the GEB, saw Howard’s maintenance as a government responsibility. In 1920, Howard desperately needed help, not with

clinical education (Freedmen's Hospital served that aspect well) but in the basic sciences. As Flexner characterized Howard's wants in a 1920 memorandum to the GEB: "The laboratory branches are starved for support and equipment."⁷⁷ He urged the GEB to contribute \$250,000 toward a \$500,000 endowment and to make funds immediately available for hiring basic science faculty and for laboratory equipment. This time, the GEB agreed and donated about \$700,000 over the next 21 years. This amount, joined with increased government appropriations, a gift from the Julius Rosenwald Foundation, and donations from black and white citizens across the country, provided Howard by the 1940s with an improved physical plant and faculty and a small but solid endowment fund. Leadership during this period from President Mordecai Johnson, and from Numa P.G. Adams, the first African-American dean of the medical school, placed Howard in a strong position to face the new problems of the civil rights era.⁷⁸

By 1950, Howard and Meharry together were graduating about 100 black physicians annually, and white medical schools were graduating a total of about 10–20 more. The Great Depression had taken its toll on potential black physicians who could not afford to attend medical school. The number of black practitioners in the United States dropped 5% between 1932 and 1942, while the number of white physicians increased 12%. The strong need for more black physicians continued, but the capabilities of the two medical schools that trained black students remained limited. The many applicants rejected from Howard and Meharry in the late 1940s had few options for attendance at other medical schools.⁷⁹ Flexner, in the early 1920s, saved the two schools he thought worth saving. But the demise of the other black medical schools had created problems Americans were just beginning to face in the 1950s.

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C A R E E R O P P O R T U N I T Y

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