IMMIGRATION, QUOTAS AND ITS IMPACT ON MEDICAL EDUCATION

BY

MICHAEL H. RUBIN

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Approved by:

David Coates, Ph.D., Advisor
Michelle Gillespie, Ph.D., Chair
Kenneth Zick, Ph.D.
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### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AAMC</td>
<td>Association of American Medical Colleges</td>
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<tr>
<td>AAP</td>
<td>Association of American Physicians</td>
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<td>AMA</td>
<td>American Medical Association</td>
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<td>AMACME</td>
<td>AMA Council on Medical Education</td>
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<td>ASA</td>
<td>American Surgical Association</td>
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<tr>
<td>BGSM</td>
<td>Bowman Gray School of Medicine</td>
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<tr>
<td>CCNY</td>
<td>City College of New York</td>
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<tr>
<td>DUSM</td>
<td>Duke University School of Medicine</td>
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<tr>
<td>ECU</td>
<td>East Carolina University</td>
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<tr>
<td>FMG</td>
<td>Foreign Medical Graduates</td>
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<tr>
<td>IMG</td>
<td>International Medical Graduates</td>
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<tr>
<td>MCAT</td>
<td>Medical College Admission Test</td>
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<tr>
<td>UNCSM</td>
<td>University of North Carolina School of Medicine</td>
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<tr>
<td>USMG</td>
<td>U.S. Medical Graduates</td>
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Abstract

For greater than a century higher education has provided the means for the immigrant class to enter the American mainstream. In no other field has this been more apparent than in the pursuit of a medical education to become a physician. This goal was most evident among the first and second generations of Eastern European and Russian Jews following the first “Great Wave” of immigration (1880 to 1914) and the Southern and Southeast Asians who arrived in the next great wave of immigration (1965 to the present). The children of these immigrant families entered medical schools in numbers far exceeding their other immigrant cohort groups and in greater proportions than their percentage of the population.

The reception by both the university and medical school establishments of these groups was very different. The sudden influx of Jewish students in the early 20th Century triggered a restrictive admission policy (quota system) while the Asian-American student a half century later encountered no such discriminatory policy. They benefitted by the legal, social and political changes that occurred in the latter 20th Century that discredited and outlawed discrimination in education directed at race, ethnicity and gender. Recent developments, however, have alarmed the Asian-American community that a return to the quota system, albeit the practice of “benign” of “soft” quotas, has become a reality directed at the Asian student. Viewed as reverse discrimination by Asian Americans, this system was designed to create greater opportunities for the disadvantaged and underrepresented minorities to be admitted to the elite colleges and medical schools.
Introduction

Immigration has had a significant impact on the health care delivery system in the United States, furnishing the future generations of medical students who provide the physicians of a growing country. The reception by the medical educational establishment of these first- and second-generation Americans aspiring to enter medical school and the medical profession has been inconsistent and at times troubling over the past century. Following the “great wave” of immigration from 1880 to 1914, medical schools opened their doors to students of immigrant families with an initial policy of acceptance and engagement. This approach was short-lived, however, replaced by a policy of restriction and discrimination in an effort to limit their growing numbers into medical schools which began in the pre-World War I era. This gatekeeper action was almost completely targeted to students of Russian and Eastern European Jewish origin, and remained a fact of life for the next half century. The restrictive policies adopted by colleges and medical schools dovetailed with the adoption of the Immigration Restriction Act of 1924 which “in a sense sanctioned the actions of concerned academic authorities.”¹

The “second great wave” of immigration, 1965 to the present, followed the adoption of the liberal, more inclusive Immigration Act of 1965. This law made it possible to open up immigration and create a pathway to American citizenship for ethnic groups previously denied or limited by past immigration legislation. Again a disproportionate number in these “new immigrant” groups elected to study medicine, especially those whose families arrived from Southern and Southeast Asian. These

“physician-aspirants,” however, encountered no significant barriers in their quest for a medical education as had been the case of the earlier Jewish cohort group. Both the similarities of and differences between these groups in their pursuit of a medical education and achieve their American Dream is striking and speaks to the evolutionary process of who we were as a racially and ethnically stratified society and what we have become as a people. This thesis will explore the influence that immigrants have had on the changing ethnicity in medical schools during the past century in the United States and the circumstances that they encountered.

Because of the subject matter, I will summarize immigration policy from the Colonial Era to the first major legislative change, the National Origins Act of 1924, followed by a history of medical education in America. The impact that the first “Great Wave” of immigration had on medical school enrollment will then be discussed with special attention to the early generations of Eastern European and Russian Jewish students seeking a medical education and the emergence of the *numerus clauses* or “Quota System,” that restricted their access both nationally and in the state of North Carolina. A discussion of the gradual dismantling of the Quota System and its demise will follow, which coincided with the next paradigm shift in immigration legislation, the Immigration (Celler) Act of 1965. This bill, which facilitated a huge influx of Asians to the United States, significantly influenced the ethnic composition of medical schools over the next decades, which continues to the present. The Asian-American medical student’s experience will be compared to that of Jewish medical students of a half-century earlier.

In conclusion, the Bakke Supreme Court decision (1978) and the issues of “reverse discrimination” and benign quotas will be presented as a cautionary tale against returning
to the era of racism and quotas that once permeated higher education and medical schools in the United States.
Immigration Policy of the United States: Colonial Era to 1924

Immigration policy in the United States, determined by the Constitution and federal legislation, continues to define the racial, ethnic and religious composition of America. Many of these policies, dating back to Colonial America, were designed to limit or eliminate immigration of certain groups found to be objectionable to the established hierarchy. Jews were denied the right of entry to New Amsterdam during the governorship of Peter Stuyvesant in the mid-seventeenth century. Many Catholics settled or migrated to Maryland, a colony founded by English Catholics (1634), avoiding the severe religious and political restriction imposed by the other colonies. The United States Constitution, approved in 1789, forbade the importation of slaves after 1808 (Article I, Section 9) which significantly impacted the African-American population in the country, although this was not passed as a discriminatory statute but rather as an anti-slavery measure.

Despite this history of restrictive strategies, the Homestead Act of 1862 was “an accommodating immigration law.” Conceived as a pro-immigration bill, it encouraged immigration by offering foreign-born noncitizens the opportunity to receive 160 acres of Western Territory public land free. They were obligated to farm the land for five years, the minimum residency required by the Naturalization Law of 1802 for citizenship. This act enabled several hundred thousand immigrants to fill the Great Plains as productive

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farmers while establishing their citizenship. In addition to agriculture, these waves of immigrants also became the miners and factory workers that provided the labor for America’s industrial expansion of the last half of the 19th Century. George Will would refer to this Act as the “door opener” to America.

Racial discrimination was a major factor in the creation of the Chinese Exclusion Act of 1882 which basically terminated Chinese immigration to the United States for several generations. The Chinese laborers who emigrated to America with the Gold Rush of 1849 were key in the construction of the Central Pacific Railroad in the late 1860s. They remained in the western states following its completion which posed a threat to the white (mainly Irish) workforce in competing for the unskilled labor market, and through the efforts of Dennis Kearney’s Workingman’s Party, the Exclusion Act effectively eliminated this workplace rival. Prior to its passage, the Chinese (90% male) comprised nine percent of the population of California.5

As further Chinese immigration dried up, the Japanese accommodated the need for cheap labor, first migrating to Hawaii as agricultural workers in the 1880s, and then to the mainland-West Coast states by the 1890s. Of the 300,000 Japanese laborers who came to the United States between 1884 and 1906 almost two thirds were “sojourners” who returned to Japan, while over 100,000 remained in the Pacific coastal states and Arizona. Again at the request of the nativist (Asiatic Exclusion League, Anti-Jap Laundry League) and organized labor elements, attempts were initiated by California politicians to restrict or exclude Japanese immigration. The Japanese government vigorously opposed such measures as racist and these proposals were temporarily shelved. With persistent

political lobbying, a “Gentleman’s Agreement” was pieced together in 1907 by President Theodore Roosevelt in collaboration with the Japanese government as a face-saving gesture for both countries. They agreed to bar the further immigration of Japanese male laborers after 1912 except in cases of family reunification. The negotiated pact was downplayed during World War I when Japan became an ally of the United States. The passage of the Immigration Restriction Act of 1924, however, resumed the policy of denying all Asian immigration to the United States except that from the Philippine Islands which became a U.S. territory following the treaty ending the Spanish American War (1900).

The Asians were not unique in feeling the brunt of xenophobic and protective sentiment. Coinciding with the great Irish immigrant stream which began in 1846, exclusionary movements became active in an America that had forgotten that they too were once immigrants. Denigrated in Thomas Nast’s cartoons for their ignorance, violence, drunkenness and religion, the Irish were caricatured as a subhuman species. The Irish created fear among the “native stock” (English, Scottish, German and Scandinavian) that their presence and Catholic religion would dilute the political influence and economic well-being of the established majority. This triggered the growth of nativist organizations which proliferated in the mid-late nineteenth century. The Know-Nothing Party of the 1850s, the American Protective Association of 1887, and the Immigration Restriction League of 1894 (a Boston-based organization of professionals

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7 Archdeacon, 100-101.

who supported literacy tests) represented examples of these groups whose agenda was sweeping America, especially in the northeast.9

As California political initiatives were eventually successful in ending Asian immigration to the United States, similar efforts were launched to discourage the “new immigration” that began in 1880 when Eastern European Jews, Italians and Slavs crowded into their ports of entry to the United States in record numbers. These groups, however, had their supporters, ranging from the conservative business community and industrialists who valued them as a source of cheap labor to the liberal progressives who believed in the promise of America and the right of those seeking it. Opportunists like Tammany Hall bosses and big city political machines not only championed this immigration but actively courted these newly-arrived Europeans for their own political gain.

The anti-immigration proponents leaned on their congressmen to stem this tremendous influx and literary tests were proposed to discourage these poorly-educated Eastern and Southern Europeans from emigrating to the United States. Although these restrictive measures were passed by Congress, they were repeatedly vetoed by the more progressive Presidents: Cleveland (1896), Taft (1912) and Wilson (1915). In January 1917 Congress was successful in overriding President Wilson’s veto, however, and passed an immigration bill (the Burnett Bill) that imposed a literacy test on the newly-arrived immigrants at their ports of entry.10 Actually European immigration was already on the decline due to World War I. The warring factions of Europe were facing

9 Link and Catton, 15-16.
10 Link and Catton, 119.
manpower shortages trying to maintain their military forces while sustaining their industrial and agricultural productivity. Because of this, the belligerent countries restricted emigration, and this effort was assisted by the physical barrier of the Atlantic Ocean, made more dangerous by unrestricted German submarine warfare. After the war, however, emigration to the United States from a war-torn, economically-depressed Europe resumed to its pre-war levels.

The post-war economic recession triggered underemployment and stiff competition in the labor market, which led to a resurgence of anti-immigration sentiment. This mood was coupled to negative stereotypical perceptions of the immigrant ethnic groups, targeting the Jews, Irish, Italians, and Slavs. These groups were identified by the popular media with organized crime, radical politics, Romanism and an anti-American ethos. They were accused of sabotaging the war effort by promoting pacifism, international socialism, and Bolshevism in addition to encouraging industrial strikes and advocating anti-war policies. The Irish-Americans, in particular, did not favor fighting “England’s War” while their Fenian compatriots in Ireland were denied statehood by the British. This feeling combined with the post-war Red Scare phenomenon provoked the Justice Department to deport many of the political activists and criminals to their countries of origin, the bulk of whom returned to Italy, Ireland, Eastern Europe and Russia.\(^{11}\) The negative tenor that these “foreigners” produced in the United States enabled anti-immigration forces to gain strength and to influence an immigration policy that remained fairly well intact over the ensuing four decades.

\(^{11}\) Link and Catton, 225-227.
The National Origins Act of 1924, also known as the Immigration Restriction Act of 1924, was conceived by a conservative congress during the administration of President Warren G. Harding and signed into law by his successor Calvin Coolidge. Spearheaded by Representative Albert Johnson (R. Washington), chairman of the Committee on Immigration, Henry H. Laughlin, a leading eugenicist, and John B. Trevor, a socialite New York lawyer, this legislation was fueled by fears that the native Anglo-Saxon strain was being diluted with genetically and racially inferior peoples. Authored by two Democratic senators, the Reed-Johnson Bill was the culmination of efforts for at least a generation to restrict immigration from Russia, Eastern and South-Central Europe. The law conversely favored acceptance of immigrants from Northwestern European countries and was formulated to reflect the percentage of those nationalities in the United States according to the 1920 Census. The annual legal immigration was reduced to 165,000 persons, 86% of this total allotted to the Northwestern European countries which was based on their percentage in the American population.

This legislation was extremely effective in achieving its goal as the number of foreign-born residents in the United States dropped from 15% in 1910 to 4.7% by 1970. The “first wave” of mass immigration between 1840 and 1920 accounted for 35 million immigrants, only to be reduced to a trickle for the next two generations. Again it was the combination of nativism, xenophobia, racism, prejudice, protective labor issues and scare politics that secured the 1924 law’s passage. Senator John F. Kennedy would later

12 Archdeacon, 171.


14 Barone, 5.
comment that “this idea was at complete variance with the American traditions. . . and violates the spirit expressed in the Declaration of Independence that all men are created equal.”15

Prior to the establishment of medical schools in America, the practicing physicians in the Colonies received their medical education either in Europe (mainly Great Britain) or through the system of apprenticeship where prospective physicians were trained under the watchful eye of a formally-educated doctor of medicine. At the time of the Revolutionary War, of the estimated 3,500 to 4,000 physicians in the colonies, approximately 400 had some formal medical education although fewer than 200 held actual medical degrees.\textsuperscript{16} Kings College in New York (later Columbia University) provided the first formal medical education in the colonies in 1767, followed by Philadelphia College (later University of Pennsylvania) in 1769 and Harvard University in Boston in 1783. By the early nineteenth century there were between ten and fifteen medical schools in the United States, most of which were located in the Middle Atlantic and New England states, although two medical schools were established in the southern cities of Richmond (Medical College of Virginia, 1838) and Charleston (Medical College of South Carolina, 1824).\textsuperscript{17} The ensuing growth in the number of medical schools was so rapid that by 1850 the number mushroomed to forty-two, most of which were west of the Allegheny mountains.\textsuperscript{18}

Following the Civil War and extending to the turn-of-the-century, the United States experienced a significant proliferation in institutions of higher education and, in


\textsuperscript{17} William G. Rothstein, \textit{American Medical Schools and the Practice of Medicine: A History} (New York: Oxford University Press, 1987), 29.

\textsuperscript{18} Starr, 42.
particular, in the field of medical education. Between 1860 to 1900 the number of students enrolled in colleges, universities and normal schools increased from 32,000 to 256,000. During this same time-frame, the number of medical schools more than doubled from 65 with less than 2,000 graduates per year to 160, graduating 5,214 physicians in 1900. The growth in the number of medical schools included eight segregated African-American and eighteen women’s medical colleges by the turn of the century. These increases fueled an oversupply of doctors relative to the general population.

19 Rothstein, 91-92.
Race and Gender Issues in Medical Education

Medical education for African-Americans and women in the United States deserves special attention because of their shared background encountering prejudice and restrictions which would become a major feature of the immigrant experience which followed in the twentieth century. Prior to the Civil War, educated freed African-American men living in the North experienced great difficulty in gaining and maintaining enrollment in America’s medical schools. A particularly ugly incident occurred at Harvard University in 1851 when a group of white medical students forced the expulsion of three black medical students because of their race. These students subsequently transferred to other medical schools (Bowdoin in Maine and Edinburgh in Scotland) to complete their medical education.20

An unintended consequence of the Emancipation Proclamation (1863) and the Thirteenth Amendment (1865) abolishing slavery was a health care disaster in the making as suddenly four million slaves forfeited their access to medical care (albeit limited) as they gained their freedom. No longer the responsibility of their white slave owners, the freed slaves’ “health care plan,” designed to keep them healthy and working, vanished overnight with the stroke of a pen. This resulted in the illness and deaths of hundreds of thousands of freed slaves “. . .a bitter irony often ignored in favor of a more triumphant narrative about emancipation.”21 A temporary stop-gap measure was the creation of the Medical Division of the Freedman’s Bureau, the “first national health system,” which


functioned as the sole medical support for the southern African-American population in the immediate post-Civil War years, somewhat offsetting the high mortality rate endured by this group. In the years following the Civil War, Howard University (Washington, D.C.) and Meharry Medical College (Nashville, Tennessee) were founded in 1868 and 1876 respectively, specifically for the education of African-American physicians.

During the Jim Crow era, six additional black medical schools were established, all of which were in the South where seven-eighths of the black population lived. None of these institutions survived the rigors of the Flexner Report (1910) except for Howard and Meharry medical colleges which would supply eighty percent of all black physicians in the United States until the mid 1960s. With the demise of these southern black medical colleges, one of which was in North Carolina (Leonard Medical College of Shaw University in Raleigh), the number of African-American physicians plummeted from an estimated six percent to two percent of the nation’s doctors who provided most of the medical care for the country’s black population (twelve percent). By 1930 there was only one black physician for every 3,000 black patients, and in the Deep South, this ratio worsened to one black physician for every 15,000 black patients. It would not be until the Civil Rights legislation of 1964-65 that opportunities for the education of larger numbers of African-American physicians became a reality as the racial ban on black enrollment practiced in most southern medical schools was outlawed. Only since 1965 have African-Americans had access to all of the nation’s medical schools in the post-

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23 Starr, 124.
Civil Rights era and since then they have maintained an admission and graduation rate in the seven percent range.

Female medical education has had an uneven trajectory in the United States, at times very similar to that of the African-American experience as prejudice and exclusionary policies created obstacles difficult to overcome. Before the era of formal medical training and apprenticeships in colonial America, women functioned as lay practitioners, providing basic medical care in the home. In the late 1700s the shift from women midwives to male obstetrical physicians who received advanced training in the new technology (birth forceps) triggered a rapid decline of women practitioners. Despite the increase in medical colleges in the early 1800s, women were generally denied access and their role in medicine gradually ceded to men with medical degrees and licenses. With the need for these credentials, the New England Medical College was founded in Boston in 1848 exclusively for women medical students. Despite this entry into formal medical education, women were ostracized by the prevailing medical societies, although they were much better received by the homeopathic physician fraternity of that period.\textsuperscript{24} Seventeen additional women’s medical colleges were established in the last half of the nineteenth century, although the overall quality of these institutions was considered substandard by the male medical establishment.

In the latter part of the nineteenth century women were being accepted at predominantly male medical schools, and by 1893-94 comprised at least 10\% of the students at 19 formerly all-male medical schools, and nationally accounted for 5\% of all physicians. A special endowment was gifted to the elite Johns Hopkins Medical School

\textsuperscript{24} Starr, 50.
because of its willingness to accept women in their program.\textsuperscript{25} This high-water mark in women’s medical education was short lived, however, as the marginal and less financially secure women’s medical colleges were forced to close their doors or merge with other institutions and by 1910 only three remained in operation. Women medical graduates dropped to 3.2\% by 1912,\textsuperscript{26} a proportion that remained fairly constant (less than 5\%) until the 1960s. Many qualified women applicants were denied admission to medical schools during these years on the grounds that getting married would limit their practice longevity.\textsuperscript{27} The Women’s Medical College of Philadelphia survived, however, and was considered the best all-women medical school, occupying a unique role in women’s health care for the next half century. The combined forces of the Women’s Rights movement and civil rights legislation in the 1960s significantly impacted women’s participation in medical education in the last decades of the twentieth century and today women now account for half of U.S. medical graduates. It is of note that the University of North Carolina School of Medicine (UNCSM) was the first (White) southern state medical schools to admit African-Americans (1951) and women (1915).

\textsuperscript{25} Starr, 117.


\textsuperscript{27} Starr, 124.
There are presently four medical schools in North Carolina: the Duke University School of Medicine, the University of North Carolina School of Medicine, the Bowman Gray School of Medicine of Wake Forest University and the Brody School of Medicine at East Carolina University. A fifth medical school in the late-planning stages and located in Charlotte will become part of the University of North Carolina system. The first chartered medical school by the North Carolina General Assembly was the Edenborough Medical College started by Dr. Hector McLean in Robeson County (now Hoke County) in 1867 which functioned for a decade until the founder’s death in 1877. Two other medical schools were established in North Carolina that were eventually discontinued, the Leonard Medical School of Shaw University located in Raleigh, and the Davidson School of Medicine in Charlotte which was founded in 1887, and changed its name to the North Carolina Medical College in 1907. Supported by private funding and given land by the North Carolina Legislature, the Leonard Medical School was created in 1882 to educate African-Americans to serve the black community. The school was in continual service until 1918 when it closed its doors due to financial and quality issues. It sent its residual students to Howard University to complete their medical education. Due to similar circumstances the North Carolina Medical College aligned itself with the Medical College of Virginia in 1914 but after 1917, it suspended operations completely.


The University of North Carolina established a two-year medical school in Chapel Hill in 1879, but with the resignation of its Dean and Professor of Anatomy, Dr. Thomas W. Harris in 1885, classes were suspended until reopening in 1890 with Dr. Richard H. Whitehead replacing Dr. Harris. Although temporarily moving to Raleigh in 1902 to take advantage of the larger clinical facilities, a suboptimal rating by the Flexner Report in 1910 convinced Dean Isaac H. Manning to upgrade the preclinical curriculum, and to terminate the clinical training. The medical school returned to Chapel Hill to become a two-year institution that “farmed out” its students the last two years to other medical schools hospitals to receive their clinical training. This situation continued until 1954 when UNCSM became a four-year school with the completion of North Carolina Memorial Hospital which provided the main clinical facilities.30

The Bowman Gray School of Medicine at Wake Forest University began as a two-year medical school in 1902, the Wake Forest College of Medicine. It remained a two-year, pre-clinical medical school, similar to the UNCSM until becoming a four-year institution in 1941. The original medical school was the vision of College President C.E. Taylor (1875-1905) to expand the educational opportunities of the College to a “great institution” but lack of financial resources limited his intentions. President Taylor’s vision was realized in 1941 when the medical school (and later the university) was coaxed to Winston-Salem, to expand to a four-year institution using the Baptist Hospital for its clinical training. An endowment from the late Bowman Gray (President of R.J. Reynolds Tobacco Co.) provided the seed money for faculty and teaching facilities.

Adopting the name Bowman Gray School of Medicine of Wake Forest University, it has become a major medical and research center in the South.\textsuperscript{31}

Although there were two previous unsuccessful attempts to establish a medical school at Trinity College in Durham, it was the generous endowment of another wealthy tobacco baron, James B. Duke, to make it come to fruition in 1927. After committing a princely sum to expand and enhance the small Trinity College into Duke University in December 1924, both Mr. Duke and the President of the University William Preston Few laid the groundwork to create the Duke University Medical School three years later. Under the able leadership of Dean (Dr.) Wilburt C. Davison and generous financial backing, the Duke University Hospital, teaching facilities, clinics and outstanding faculty were rapidly put into place, and the medical school graduated its first class in June 1932. With a combination of excellent funding and an innovative, constantly changing curriculum, the DUMS ranks among the nation’s elite, progressing from a regional institution to one of international acclaim.\textsuperscript{32}

A combination of a the state’s growth in population in addition to the steady attrition of physicians in eastern North Carolina prompted the chancellor of East Carolina College, Dr. Leo W. Jenkins, during the 1960s to inquire the state agencies of the feasibility of establishing a medical school in this part of the state. Successfully making his case, in the early 1970s, a one-year medical school was started at East Carolina University in Greenville whose students finished their medical curriculum at the University of North Carolina in Chapel Hill. In 1974 state funds voted by the General

\textsuperscript{31} Coy C. Carpenter, “A History of Wake Forest University in the Field of Medicine,” Ibid, 484-503.

\textsuperscript{32} Wilburt C. Davison, “The Duke University School of Medicine,” Ibid, 527-542.
Assembly initiated a four-year medical school at ECU, designed to increase the flow of physicians to underserved eastern/central North Carolina with a priority of training minority and economically-disadvantaged students who would provide future generations of physicians to practice in these areas. The medical school graduated its first class in 1977 and in 1999 was renamed the Brody School of Medicine at East Carolina University to honor the family that had contributed to the success and growth of the institution.\textsuperscript{33}

Medical Education at the Turn of the Century: The Pre-Flexner Era

An undergraduate education was not a prerequisite for medical school enrollment in the early twentieth century. Only eight percent of medical students had college degrees compared to those attending law (21%) and divinity schools (25%). Despite steadily more demanding entrance requirements for medical students, the oversupply of medical schools created an excess number of places in most freshmen classes, and many of these underutilized schools resorted to advertising and recruitment campaigns to fill their vacancies. These “marketing” techniques were particularly employed by the financially-strapped, lower quality institutions. The better-endowed, higher caliber institutions were busy innovating their teaching curriculum after the European (Viennese) model in the late nineteenth century. This approach emphasized didactic lectures in the classroom, the study of the basic sciences with the necessary laboratory facilities, and clinical teaching, making use of both university-affiliated and large municipal hospitals. A full-time faculty and the novelty of written exams replacing oral examinations were important features of this model. Professional medical organizations in the United States such as the Association of American Physicians (AAP), the American Surgical Association (ASA) and the American Medical Association (AMA) endorsed this approach, and many of its members who were recognized as the country’s leading physicians obtained faculty positions at schools promoting these progressive programs.35

34 Rothstein, 93.
35 Rothstein, 107.
Although the quality of the medical schools adopting these measures was greatly enhanced by the enrichment of their teaching programs, a troubling number of institutions were exposed for their glaring inadequacies in crucial areas of their curriculum. This became a cause of major concern for the AMA which began publishing the annual reports of the licensing exam results for each state and medical school, and it became apparent that certain schools’ students performed persistently poorly, reflecting their suboptimal education. As in the case of women’s medical schools, some of these institutions ceased operation while others merged with those in similar straits. In order to obtain adequate funding and better facilities, several medical colleges affiliated with large universities. By 1910 twenty-seven medical schools were forced to close their doors while another forty-three aligned themselves with academic institutions which resulted in an overall reduction of medical students from a peak of 28,142 in 1904 to 21,526. These developments impressed the AMA Council on Medical Education (AMACME) that there were significant variations in the quality of medical schools and the students they were graduating. They subsequently requested the Carnegie Foundation for the Advancement of Teaching in 1909 to impartially investigate this problem and the Foundation readily approved funds for this project. This investigation resulted in landmark changes in the American system of medical education. Its impact continues to be felt more than a century later as quality and curriculum issues confronting both faculty and administrative officials are constantly addressed.\textsuperscript{36}

\textsuperscript{36} Rothstein, 144-145.
The Flexner Report

Abraham Flexner, a secondary school teacher with no previous medical training, was hired by the Carnegie Foundation to undertake this task. He used the Johns Hopkins Medical School as the standard by which he measured all other American and Canadian medical schools.\(^{37}\) This institution, founded in 1893 and where his brother Simon was a respected faculty member in both the research and clinical areas, incidentally was modeled closely after the Viennese benchmark. This family-tie afforded Flexner unique access to the physical plant, research and teaching facilities, and to the faculty. With a secretary from the AMACME, he conducted his field work in 1909-1910 visiting each of the 160-plus medical schools to assess their admission requirements, teaching faculty and curriculum, while appraising the physical plant, including the affiliated teaching hospital, laboratory, research and clinical facilities.\(^{38}\)

In 1910 Flexner published his observations, in *Medical Education in the United States and Canada*, stirring the medical establishment in controversy that persisted over the next several years, interrupted only briefly by the First World War. His conclusions favored medical schools associated with universities, and teaching hospitals that maintained ongoing clinical and bench research. He was critical of the for-profit and smaller independent institutions whose funding was usually inadequate or unreliable, and who maintained minimal or no connection with clinical-teaching hospitals. Most of these medical schools also lacked an active, full-time faculty and adequate laboratory and

\(^{37}\) Starr, 116.

\(^{38}\) Starr, 119.
research facilities. Flexner was credited with influencing several of the suboptimal medical schools to shore-up their deficiencies, especially in the areas of laboratory training and the teaching of basic medical sciences. Many of the medical schools judged to be substandard, however, were unable to comply with Flexner’s recommendations, and a “weeding out” process occurred over the next two decades.\(^{39}\) The number of medical schools gradually declined, and by 1932 only 66 had survived, a figure that remained fairly constant for a generation. Although the final report had its critics, “...it is filled with flippant and unwarranted judgment and is based on hastily-formed opinions resting upon careless observation,”\(^{40}\) it paved the way for medical education in the United States to become a carefully monitored and regulated discipline. The AMA approved the methodology and findings of the report and agreed “that the present condition of the medical profession, overcrowded by ill-trained physicians, was very unsatisfactory.”\(^{41}\)

The CME arm of the AMA followed up the Flexner Report by obtaining additional evaluations of the quality of American medical schools and it recommended that the licensure of all medical schools, previously sanctioned at the state level by the Federation of State Medical Schools, require AMA approval. They further advocated that all approved medical schools become members of the Association of American Medical Colleges (AAMC) which they did. The rigid standards imposed by the Flexner Report and the AMACME reduced medical school enrollment by 1930 to such a degree that a “doctor shortage” was predicted when the ratio of 150 physicians per 100,000 population

\(^{39}\) Rothstein, 145-149.

\(^{40}\) Rothstein, 145.

\(^{41}\) Rothstein, 145.
dropped to 130 doctors per 100,000 population. The AMA was accused by respected economists Simon Kuznets and Milton Friedman of creating “monopolistic barriers” for entry into the medical profession by reducing the number of physicians for purely economic reasons (fewer providers = larger pool of patients per physician).  

For this reason the Federation of State Medical Schools, suspicious of the AMA functioning as a trade organization, bypassed the AMACME in favor of the AAMC as its standardizing agency “for all matters of premedical education, course of study, and educational requirements for the degree of Doctor of Medicine.”

Prior to World War I admittance to medical school was not the competitive business it would become. At Columbia University Medical School obtaining a place in the freshman class “. . . was not a very complicated affair. . . a matter of course. . . obtaining acceptance after the most cursory examination of their credentials if they were graduates of the college.” Prospective applicants from outside colleges had to meet “minimum requirements for admission which usually consisted of a specified number of years of college work and sometimes a minimum age and health standard.”

With fewer medical schools operating in the post-Flexner Report era, the number of spaces for aspiring physicians decreased accordingly. The competition among medical school applicants became intense to the extent that many qualified pre-med students were denied admission due to the limited number of places available, especially those schools located in the densely populated cities of the northeast. Although the criteria for

42 Starr, 143.

43 Rothstein, 149.

acceptance was theoretically based on undergraduate academic performance and standardized tests, including the Moss Scholastic Aptitude Test (1929) and the Medical College Admission Test (1948), factors other than academic achievement weighed into the selection process. Known as the “selective admission policy,” this gave admission committees the flexibility of choosing and refusing applicants using additional variables including a family medical pedigree and socioeconomic and cultural factors such as wealth, social position and “character.” As the number of medical school places dwindled in the post-World War I era, the religion and nationality (ethnicity) of medical school applicants became an important consideration, and at times the decisive metric of acceptability in the admission process.\textsuperscript{45}

\textsuperscript{45} Wechsler (1977), 162-171.
The Emergence of the Quota System

“Columbia College, a daughter of the great Trinity Church, an alma mater of men like Hamilton, Jay, Livingston . . . can afford to enroll a raw Serbian immigrant among its students; train me, an uncouth employee of a cracker factory, to become one of its alumni?” Michael Pupin

“The restrictions on Jewish entry into elite institutions, which, in part, reflected the competitive concerns of the non-Jewish middle class and elites . . .” Seymour Martin Lipsett

At about the same time as the release of the Flexner Report, the elite universities Harvard and Columbia became concerned about the changing ethnic composition of their institutions. In particular the presidents and boards of trustees expressed anxiety about what they considered a disproportionate influx of Jewish students. These were the first and second generations of the Russian and Eastern European Jewish immigration that occurred between 1880 and 1914. During this period the Jewish population in the United States increased from less than one percent to four percent, and in New York City from three to thirty percent. At the turn of the century there were only modest increases in the number of Jewish students in the urban colleges and universities of the northeast and midwest, but by 1910 Jewish students made up forty percent of the student body at

46 Wechsler (1977), 132.
Columbia and twenty-two percent at Harvard. The growth spurt of Jewish students at Columbia also coincided with the recent installation of a subway stop at Morningside Heights which facilitated travel from the tenements of the lower east side of Manhattan. The sons of immigrant Jews “wanted desperately” to enter the mainstream of American life and they believed that higher education provided the means to achieve this.

Although the academic preparation of these students was similar to and often exceeded that of their non-Jewish peer group, a combination of old-fashioned anti-Semitism and Jews being perceived as “parvenu” fueled a negative image of the Jewish student. This ethno-religious group was particularly identified for a number of “undesirable traits” and their excessive numbers on campus “threatened to alter the traditional character of the college.” The unfavorable qualities attributed to this newest wave of Eastern European immigrant Jews included poor hygiene, clannishness, aggressiveness, boorishness, “lack of school spirit” and an overall lack of gentility. These adverse features were not identified with the German Jews who preceded their Russian and Eastern European co-religionists by two generations (“The Forty Eighters”). It was also felt that this new generation of Jewish students was not seeking intellectual refinement and education in the classical sense but rather using universities as vocational training centers to prepare themselves for a career. University officials felt that these Jewish students were eschewing the study of Greek, Latin, philosophy and the humanities for the grinding disciplines of economics, sociology and the math and sciences. This

49 Steinberg, 20.


51 Steinberg, 12-21.
represented a departure from the traditional education that was so much a part of the
eastern elite prep schools where many of the higher educational establishment attended.\textsuperscript{52}

To contain this “Jewish problem,” a series of measures was enacted to limit their
enrollment. Patterns of anti-Jewish discrimination surfaced in the latter part of the
nineteenth century among the social and business elite, mainly restricting prominent Jews’
access to social and civic clubs, resort accommodations, certain neighborhoods, and some
industries.\textsuperscript{53} This particular bias had only a minimal presence in the halls of academia.\textsuperscript{54}
But this changed when both Columbia and Harvard Universities went “on the record”
announcing selective admission policies aimed at controlling the entry of Jewish students
at their institutions. Columbia University President Nicholas Murray Butler who
championed an elite “natural constituency” of students initially approved the policy of
selective admissions in 1918 to contain the growing enrollment of New York City Jews at
his institution.\textsuperscript{55} President Abbott Lowell of Harvard (1909-1933) followed Butler’s lead
when he released a statement to the \textit{New York Times} on June 2, 1922, that because of a
shortage of classroom and dormitory space the “proportion of Jews at the college” will be
limited.

Columbia College Dean Fredrick P. Keppel (1910-1918) asserted there were
“desirable and undesirable Jewish students,” the former who had “the advantage of
decent social surroundings for a generation or two (usually German Jews), who are

\textsuperscript{52} Wechsler, 148-150.

\textsuperscript{53} Lipsett, 161.

\textsuperscript{54} Wechsler (1984), 648-649.

\textsuperscript{55} Leon Sokoloff, M.D. “The Rise and Decline of the Jewish Quota in Medical School Admissions,”
entirely satisfactory companions” and the latter who came from Eastern Europe and who often by hard work and often sacrifice prepared themselves for college might prove less satisfactory.\textsuperscript{56} Application forms were expanded to include religion, place of birth of parents, racial origin and mother’s maiden name to determine the “Jewishness” and nationalities of candidates. Keppel added personal interviews (to assess “character”) and employed regional quotas all of which proved effective in reducing the number of Jewish students.\textsuperscript{57} Several of the prestigious colleges throughout the country followed suit with the selective admission policy although they were less overt and subtler, often denying the presence of a discriminatory quota. Jewish enrollment at the elite schools dropped accordingly, and at Harvard College Jewish student enrollment declined to 10\% by 1928. At Columbia College fewer than one in four students were Jewish by the late 1920s, and at Yale University by the early 1930s Jewish students were reduced to eight percent of the student body (formerly 13 to 15\%).\textsuperscript{58} When confronted with those numbers, universities were quick to protest that their actions were not prompted by anti-Semitism, distancing themselves from the state-approved policy that was gathering steam in Nazi Germany.

The quota system was not visited on the large Catholic ethnic groups, the Irish and Italian nearly to the degree that it impacted the Eastern European and Russian Jews. Although Catholic ethnic immigration either preceded (Irish, German) or paralleled (Italian, Slavic) Jewish immigration, higher education did not hold the priority with these

\textsuperscript{56} Wechsler (1984), 650.

\textsuperscript{57} Wechsler (1984), 650-652.

groups that Jews attached to it. Very early in their immigrant experience, Jews realized that economic and social advancement was dependent on obtaining the best education possible and they took advantage of public educational facilities that were provided at both the high school and college level, e.g. CCNY. Catholics were not as receptive of the public school education which in many systems included Protestant prayer and church services as part of their “secular” curriculum. By the mid-nineteenth century many Catholics elected to develop their own parochial system of parish schools and Catholic colleges.\(^5\) This action delayed their entry into secular higher education which afforded them the opportunity to become more fully assimilated in the prevailing culture as not to provoke the xenophobic reaction that was associated with the first and second generation Jewish students. As the third and fourth generation Irish and Italians entered the American university system, their acculturation in the American mainstream was more complete. In this post World War II climate anti-Catholic Irish-Italian prejudice was also declining on the American landscape.\(^6\)

\(^5\) Steinberg, 33-55.

\(^6\) Steinberg, 115.
The Impact of the Quota System on American Medical Education

“I believe that relatively a high percentage of Jewish students are of a neurotic temperament.” Dean W.J. Moss, University of Georgia School of Medicine, 1934

“. . .The Jewish student does not have as high an ethical standard as the average Christian student that is, he is more apt to be commercially inclined, and yet we have exceptions to this general impression.”
Dean H.R. Wall, University of Kansas School of Medicine, 1934

Jewish enrollment in medical schools closely paralleled their experience in undergraduate schools, especially in the large cities of the northeast and Midwest. After 1880 Jewish students’ desire to enter the medical field far exceeded other segments of the American population. Surveys of ten major cities over five-year spans revealed that there were only seven Jewish medical graduates between 1875 to 1880, which burgeoned to 2,313 between 1931-1935. The elite medical schools, alarmed at this rapid increase, embarked on a quota system following World War I to limit their Jewish enrollment similar to what occurred at the college level.

Columbia University, a leading practitioner of the selective admission policy, witnessed a dramatic drop in its Jewish medical student enrollment from a peak of 53% in 1919 to 19% in 1924. Matriculation of Jewish students reached its nadir of 10 to 12% in the pre-World War II years despite an abundance of qualified applicants. Medical


62 Halperin (2001), 152.

63 Sokoloff, 498.
school administrators justified these statistics with data showing that Jews made up only 14% of the population of New York State and their numbers at Columbia’s medical school (The College of Physicians and Surgeons) reflected a fair representation of these percentages. The other rationale for this quota policy was that by limiting the number of Jewish students a more acceptable “geographic distribution” was possible. Administrators reasoned that since Jewish applicants were overrepresented in urban areas and large cities, by restricting their access to medical schools more places could be allocated to those students with a greater potential of practicing medicine in underserved small town and rural communities.

Both private and state medical schools followed Columbia’s example, despite the anti-democratic character of the system and the flawed arguments. Cornell University Medical School, also in New York City, adopted its sister Ivy League restrictive policy by adhering to the 14% acceptance rate for Jewish students, e.g. admitting ten Jewish students in a class of eighty in 1940. This occurred despite Jews comprising 60% of the applicants, resulting in one of seventy Jewish students being accepted as opposed to one in seven non-Jewish students. By 1941 only 4% admitted at Cornell were of Jewish ancestry, a significant decline from 40% in 1920. Most New York medical schools followed these precedents with Long Island University and Syracuse University reducing their Jewish student enrollment from 42% in 1932 to 14% in 1940 for the former, and from 19.4% in 1936 to 6% in 1942 for the latter. At Yale Medical School in the adjacent state of Connecticut, the Dean (Wintenitz), himself from Austrian-Jewish origin, left

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specific instructions that applications needed to specify Catholic or Hebrew and advised his admission committee, “Never admit more than five Jews, take only two Italian Catholics, and take no blacks at all.” Of the major New York medicals, only New York University appeared to disregard the quota, admitting classes which averaged 40 to 50% Jewish students despite “pressure to conform to the prevailing pattern of discrimination.” The University of Illinois School of Medicine was also cited as an institution which resisted the quota system.

Many of the medical schools that embraced the quota policy accomplished their objectives by limiting admissions from Jewish-predominant undergraduate colleges including City College of New York (CCNY), Brooklyn and Queens College. CCNY witnessed a decline in its student’s rate of acceptance to medical school from 58.4% in 1925 to 15% in 1943. Disheartening to the Jewish applicants from CCNY was that 80% of their Gentile classmates were admitted to medical schools while only 20% of Jewish students gained admission. This “planned discrimination” was particularly practiced by the elite medical schools including Cornell, Johns Hopkins, Dartmouth, Yale and Harvard in spite of these New York City public colleges academically “measuring up” to the best undergraduate schools. By the 1940s only one in thirteen Jewish applicants were accepted to medical school despite an applicant pool estimated between 35 and 50%. Between 1925 and 1945 Jewish medical school enrollment declined by fifty percent.

66 Halperin (2001), 143-144.

67 Kingdom, 395-399.

68 Halperin (2001), 149-150.

69 Kingdom, 394-395.
overall, a precipitous drop of 40% occurring between 1937 and 1940. During this time frame non-Jewish acceptance rates ranged between two-thirds to three-fourths. When an inquiry was made in 1940 to the 78 U.S. and Canadian medical schools exploring whether they enforced a quota system, of the 65 schools that responded none admitted to such a practice excepting the 17 southern schools which denied African-American students consistent with their Jim Crow policy.

Despite these denials, Dean Willard C. Rappleye of Columbia University Medical School believed various social, religious and racial groups in medicine ought to parallel their proportion of the population. Agreeing with this assertion, Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*, admitted in 1939 that Jewish boys applying to medical schools were turned down “simply because they were Jewish” but he justified this on the basis that they already represented 15 to 20 percent of American doctors. Being aware of the discriminatory policies adopted by most and certainly the elite medical schools, Jewish students applied to a far greater number of medical schools than there non-Jewish counterparts. From 1935 to 1939 there were 5.5 times as many applications received from Jews than Protestants or non-Italian Catholics. The number of applications per applicant doubled among the Gentile group from 1.2 in 1920 to 2.4 in 1935-39, while the increase among Jewish applicants was ten-fold from 1.27 in 1920 to 12.51 from 1935-39. During this time only one-third of Protestant and 40% of the non-Italian Catholic applications were rejected compared to a 90% rejection.

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70 Kingdom, 393.

71 Kingdom, 396.

72 Kingdom, 397-398.
rate among Jewish applicants.\textsuperscript{73} Because admission to American medical schools became so problematic for Jewish students, a sizable number applied and experienced no difficulties being accepted to European institutions. More than 90\% of Americans studying in European (mainly English and Scottish) medical schools were Jewish, with a peak of 2,052 students in 1932-33.\textsuperscript{74}

\textsuperscript{73} Theodore Leskes, “Multiple Applications for Admission to American Medical Schools.” \textit{American Jewish Congress: Commission on Law and Social Action.} (1948) 3-11.

\textsuperscript{74} Sokoloff, 504-505.
The Quota System in the North Carolina Medical Schools

The list of medical schools that applied “a rigid quota system denied in words but applied in fact”\(^75\) included North Carolina’s only four-year medical institutions in 1945, Duke University School of Medicine (DUSM) and the Bowman Gray School of Medicine (BGSM) of Wake Forest College. The BGSM clearly stated in its handbook that priority was given to Wake Forest College graduates, North Carolina residents, and residents of the region surrounding piedmont North Carolina, i.e. East Tennessee, southwest Virginia, and western South Carolina. In 1940 the average national ratio for physicians was one per 740 citizens, but in North Carolina it was less than half (1:1,554) and in rural areas it was less than a fourth (1:3,613) the national average. The BGSM, being a private school, did not receive the generous state funding that UNCSM received, nor did it have the rich endowment of DUSM. They did, however, receive a capitation fee from the state of North Carolina for educating in-state medical students which considerably helped their sometimes precarious financial status. Usually up to 90% of its student enrollment came from North Carolina and adjacent states.\(^76\) After this small Baptist medical school achieved four-year status following their move to Winston-Salem in 1941, they maintained their Jewish enrollment in the two to six percent range until the late 1960s. Again denying an anti-Jewish bias, it was apparent that Jewish applicants from the northern cities were evaluated more critically by the admission officers following their interviews. Telling anti-Semitic comments were not part of the record although such

\(^{75}\) Kingdom, 398.

\(^{76}\) Memorandum Concerning Admission and Other Educational Policies of The Bowman Gray School of Medicine. Prepared in the office of Mr. Lloyd Aukerman, VP in charge of Public Relations and Alumni.
terms as “. . . big city boy, study grind, not well-rounded, not a good match,” and “speaking New Yorkese” sprinkled some of the assessments, many of these qualities identified with Jewish students from the north.77

Although the Duke University Medical School was identified as an institution that restricted Jewish enrollment in the pre-World War II era, no stated policies or communications were discovered to confirm this. Both at the undergraduate and medical school level loose geographic limitations were enacted to favor students from North Carolina and neighboring states. A Methodist, coeducational institution, the Jewish population in North Carolina was less than 1% when Duke College’s Jewish enrollment averaged 3% men and 2.3% women in the 1930s, during which its medical school Jewish enrollment ranged between 8 and 16%.78 There is no question, however, that the long-standing Dean of the Medical School, Wilburt Davison (1927-1960) was sensitive to the “Jewish problem” of overrepresentation and the anti-Semitic policies enacted by medical schools to deal with it. In rambling, hand-written notes obtained from the Duke Medical Library Archives, Davison recognized the presence of a quota system nationwide and offered rationalizations for its existence. He would write, “Jews have a twenty-four fold greater urge to study medicine. . . they are a big city people whose big city ways make it difficult to adjust to rural people in the practice of medicine. . . Jews do not migrate to rural districts where physicians are so badly needed. . . they have difficulty in amalgamating.” These were written in the mid-1960s, when the Dean was retired and in

77 BGSM Medical Library Archives, Notes from the Office of Admissions.

his 80s and one could argue whether they were sincerely held observations or the reflections of a guilty conscience that promoted an unjust system.\footnote{Memorandum. Conrad Huffman, Jr., to William Preston Few, Dec. 4, 1933, Davison Papers, Box 110, Duke University Medical Library Archives.}

The University of North Carolina School of Medicine (UNCSM) was an adherent of the Jewish quota system, and most likely would have been recognized as such if it hadn’t been for an incident that occurred in the fall of 1933. Although the University had operated a two-year medical school since 1879, it had not achieved four-year status until 1954. At the end of their second year students were sent to other institutions to complete their medical education. In October 1933 Frank Porter Graham had been President of the University of North Carolina for three years when he was made aware that a qualified Jewish applicant was refused admission to the School of Medicine because of his religion. President Graham confronted the highly-respected Dean of the UNCSM, Dr. Isaac H. Manning, who explained the student’s rejection on the basis of the medical school’s policy of accepting only ten percent of qualified Jewish applicants for each class (four in a class of forty in 1933). Manning explained that the practice was adopted because of the difficulty of placing Jewish students into four-year programs many of which maintained the quota system, and this task would be made simpler by keeping the number of Jewish students at the ten percent level at UNCSM. President Graham did not agree with this approach, however, explaining that a qualified student should not be refused the right to pursue his education on the grounds of being Jewish and enjoined the dean to accept the
student in question. Dean Manning refused to accept President Graham’s intervention and he subsequently resigned his post.\textsuperscript{80}

The popular dean’s resignation had far-reaching repercussions, as many of the medical school faculty and alumni supported Dean Manning, not necessarily on the basis of his discriminatory policy but because of loyalty and the belief in the autonomy of the medical school. Most of the state and national press backed the president, however, and an outpouring of correspondence from religious and liberal groups around the state praised his actions. When this incident occurred Hitler had been in power in Germany for nine months, but already his anti-Semitic decrees had made a negative impression on American public opinion. An editorial in the \textit{New York Herald Tribune} praised Graham’s position nationally, while the state press including \textit{The Fayetteville Observer} and the \textit{Raleigh Times} recognized his stance as “anti-Nazi” or as the \textit{Raleigh News and Observer} expressed, “No Aryan Doctrine at Chapel Hill.”\textsuperscript{81}

In the aftermath of the Dean’s resignation, Graham deflected the criticism directed at Dr. Manning by appointing him as a professor at the medical school. In discussing the affair President Graham concluded, “I trust it is not necessary for me to express my deep appreciation of the character and services of Dr. Manning both as head of the Medical School and as an able teacher and fine person. . . The position I have taken is simply that there shall be no discrimination on a quota basis or any other basis because a boy is of Jewish descent.” Not all on the UNC campus were supportive of Graham’s

\textsuperscript{80} Warren Ashby, \textit{Frank Porter Graham: A Southern Liberal} (Winston-Salem: John F. Blair, Publisher, 1980), 128-129.

\textsuperscript{81} Box 13, Folder 519, in Office of President of the University of North Carolina (System): Frank Porter Graham Records #40007, University Archives, Wilson Library, University of North Carolina at Chapel Hill.
approach, and Professor Wesley Critz George of the Zoology Department wrote to Graham that the restriction of Jews was important “. . . to protect another race and culture.” He continued that President Graham’s treatment of ethno-racial issues “is almost surely to lead not into the smooth waters of universal amity but into the stormy seas of race conflict.”82 Despite President Graham’s mediation, a de facto quota system continued to the mid-1950s when UNCSM became a four-year program as the number of Jewish medical students remained in the 10% range, a policy justified by the priority given to in-state and regional applicants.83

82 UNC Medical School Library Archives, Chapel Hill, N.C. Letter from Wesley Critz George to Frank Porter Graham, Box 40. Graham Papers.

The Dismantling of the Quota Systems

“I do not believe that any restriction should be placed on any man regarding his religious beliefs. The field of practice is and ought to be open and restriction should only be placed to the degree that men are sufficiently prepared in their premedical studies to enable them to appreciate and take advantage of their medical studies.”

Dean Frank Vinchenhaler, University of Arkansas School of Medicine, 1934

Challenges to the quota system were few and ineffective until the post World War II era despite a growing knowledge of its presence. Dean A.M. Schwitella of the St. Louis University School of Medicine criticized its existence in a national meeting of the AAMC in 1928, but the organization took no action and remained silent. Journalists Heywood Brown and George Britt investigated anti-Semitism practiced in the American universities in their classic exposé *Christians Only* (1931) noting, “Yet the question of discrimination against Jews in medicine is the most delicate and difficult chapter in the whole history of prejudice in America. There is less frankness here, more cross currents and division of opinion, greater danger than an intrusion of comment may bring down the wrath alike of those who discriminate and those discriminated against.”

At about the same time, leaders in the Jewish community became concerned about the quota policy and conducted their own research. Studies by Rabbi Lazeron of Baltimore and by Dr. Harold Rypins, secretary of the New York State Board of Medical Examiners, were presented to the AMACME and the AAMC. Their data revealed the

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84 Halperin (2001), 150.

discrepancy of a much smaller percentage of Jewish applicants admitted to medical schools than non-Jewish applicants despite superior academic achievement as undergraduates. Both professional organizations convinced these investigators that Jews, who comprised 3.5% of the population accounted for 17% of all medical students in the country and were entering a profession that was “already greatly overcrowded.” The Rabbi refused to accept anti-Semitism as a factor in “the proportional representation” argument and concluded that more Jews in an “overcrowded field not only aggravates the general difficulty but creates a problem for the Jewish people as well as for the Jewish medical student. Jews as such are not entitled any more than any other group to a greater or lesser percentage of doctors.” Dr. Rypins concluded after meeting with these authorities that there was “no evidence of racial or religious discrimination in the admissions of applicants to medical schools” reverting back to the statistic of a 17% acceptance rate of Jewish medical students.

This accommodation demonstrated efforts to assimilate with the existing Anglo-Saxon power structure, as these Jewish leaders tried to avoid stirring controversy that could foment anti-Semitic sentiment.\(^{86}\) Rabbi Lazeron went so far as to suggest that those Jewish students who were unjustly denied admission to medical school should explore alternative educational opportunities in other, less crowded career pathways. This type of settlement was not atypical of the rabbi’s Sephardic origins, a caste of Jewry that had established themselves in America since the early Colonial Era, and like the German Jews who followed them in the mid-19\(^{th}\) Century, they became well integrated into the social and power elite of early 20\(^{th}\) Century America. The later arrival of Russian-Polish

immigrant Jews with their “protest and agitation,” the very group challenging the
numerus clauses, were an embarrassment to these assimilated “Grandees” who opted for
sweeping this unpleasantness under the rug.\(^\text{87}\)

Jewish and human rights groups made more robust efforts to expose and discredit
the quota system during the early 1930s. The American Jewish Committee in 1931 and
the National Conference of Jewish Social Service the following year expressed concern
that Jewish students were restricted from a medical education despite high academic rank.
The canard of “proportional representation” was denounced by the National Conference
of Christians and Jews later in 1935 as un-American. It was not until the end of World
War II that more concerted attempts to eliminate the quota system were initiated when
New York City Mayor La Guardia created a Unity Commission to report on bias in
higher education. Their findings confirmed a pattern of discrimination against Jews and
to a lesser degree Catholics among both city and out-of-town institutions. Columbia’s
College of Physicians and Surgeons narrowly withstood a legal challenge by the New
York City Tax Commission and the New York State Attorney General’s Office in 1946
to remove their tax-exempt status because of its racial and religious discriminatory
practices. Despite the Education Practices Act, championed by President Truman and
passed by the New York State Legislature in 1948, a 1952 study revealed that 76% of
Gentile New York State medical scholarship winners versus 36% of Jewish winners were
accepted at New York medical schools. Although Pennsylvania adopted similar
legislation, a 1957 report showed discrimination by the University of Pennsylvania

Medical School directed at undergraduate Jewish students from both Temple and Penn. In the post-war firmament, again the AAMC remained strangely silent.

The selective admission policy had a lesser effect on medical school admissions for the other large ethno-religious immigrant groups, the Irish and Italian, during the period 1920 to 1965. As previously mentioned there was a greater delay of these groups entering institutions of higher learning, giving them more time to assimilate into the national culture, thus diluting their “foreignness” and making them more acceptable to the White, Anglo-Saxon, Protestant (WASP) educational power structure. In the Catholic parochial system of higher education which extended into professional schools, gifted students were identified and encouraged to attend Catholic medical schools where traditional church teachings were rarely challenged, as might occur in secular medical institutions.

Although Catholic medical schools admitted students of all faiths, the significant majority of those admitted were Catholic. In 1940, for example, 85% of Georgetown University’s medical students were Catholic, approximately one-fifth of the students of Italian ancestry. Although the other major Catholic medical colleges, all located in the Midwest (Marquette, St. Louis, Creighton and Loyola-Chicago), did not have the extremely high number of Catholic students as Georgetown, one half to two thirds of enrolled students were Catholic. These figures are contrasted with admission rates of 3% and 1.5% at southern secular medical schools such as the University of Virginia and Bowman Gray School of Medicine in North Carolina, states where Catholics made up less than one percent of the population. Secular medical schools in cities with large

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88 Halperin (2001), 162-166.
89 Steinberg, 2.
Catholic populations enrolled Catholic students in greater percentages such as Boston University (50%), Tufts Medical School (50%) and the University of Buffalo (38%). Even the elite Yale University Medical School in New Haven matriculated 14% Catholics.\footnote{Kingdom, 397.}

It is noted that Italian Catholics did not fare as well as their Irish and German coreligionists in getting into medical school. Data for 1950 showed a lower acceptance rate (14.2%) than that for non-Italian Catholics (32.5%) in New York medical schools, although this gap closed slightly by 1952 (29% vs. 42%).\footnote{Howard E. Wilson, “A Study of the Policies, Procedures and Practices in Admissions to Medical Schools in New York State.” 1953, 27-41.} This confirmed an earlier study by the American Jewish Congress in 1948 which revealed that non-Italian Catholics were accepted to medical schools on a par with white Protestants, a rate significantly greater than for Italian Catholics, despite similar scholastic achievement levels.\footnote{Leskes, 7-11.} These studies suggested that a nationality bias was also operative in the selection of medical students.

Towards the end of World War II, and the immediate post-war period, there was a slight softening of the selective admission policy prompted by the physician shortage, the revelation of the Holocaust, and the passage of the GI Bill in 1948. The latter enabled greater segments of society the opportunity to participate in higher education previously denied them by economic and social factors. The growing awareness of discriminatory practices imposed by universities and medical schools affected public opinion as undemocratic and racist, the very issues that were at the forefront of the war that was just
fought. As a result legislation was enacted, the Education Practices Act (Quinn-Ollife Act) in New York (1948), followed by similar bills in Massachusetts and New Jersey which required “. . .all applicants to educational institutions of post-secondary character be considered without regard to race, religion, creed, color, or national origin.”93 The State Board of Regents of New York pressed for the elimination of the practice of certain medical schools favoring graduates of particular select colleges and the misuse of “geographic representation” used to deny admission to qualified students. As more states enacted their own version of the Education Practices Act throughout the 1950s and early 1960s, the Civil Rights legislation further guaranteeing equal protection was passed in 1964-1965, and restrictive quotas in education became an anachronism.

Although blatant anti-Semitism was persistently denied as a rationalization for the Quota System, an incident occurred at the Emory University Dental School which questioned this disclaimer. In 1960 Emory president Dr. Walter Martin was presented with detailed documentation by the Anti-Defamation League of a pattern of anti-Jewish bias by the Dean of the Dental School, John Buhler, following his installation in 1948. Over the next decade 64% of Jewish students either flunked out or needed to repeat, whereas only 15% of the Gentile students experienced similar difficulties. In comparison only 13% of Jewish students had inordinate academic problems from 1937-1944 prior to Dean Buhler’s appointment. Of interest only 3.8% of Jewish medical students at the same institution experienced academic difficulties from 1948-1958, none of whom flunked out. When confronted with these allegations, Dean Buhler resigned and Emory University President Martin acknowledged “All concerned. . . are convinced that the long period of

93 Wilson, 50-51.
foul air at Emory University has been entirely cleared for good.”94 A public apology by now-President Dr. James W. Wagner was announced February 22, 2013, during a conference on social change.95 In the post-World War II era there was a shift in attitudes regarding social and ethno-racial issues among Americans as the country became more tolerant and accepting. These changing positions had a significant impact on the legislative approaches to immigration reform.96


96 Archdeacon, 179-180.
Temporary accommodations in immigration policy occurred in 1943 with the repeal of the Chinese Exclusion Act (China was our wartime ally) and again in 1948 when Congress passed the Displaced Persons Act. The latter facilitated the admission to the United States of over 400,000 Europeans displaced by World War II, although it did not apply to non-Europeans displaced by other conflicts such as occurred in Palestine and India. In 1952 Congress approved a bill allowing Braceros, the temporary agricultural workers from Mexico who were “imported” to work the farms of the Southwest during the World War II farm labor shortage, a quick path to legal citizenship because of their contribution to the war effort.\footnote{Barone, 154-155.}

That same year (1952) Congress passed the Immigration and Nationality Act (McCarren-Walter Act) which eliminated race as a barrier to immigration and in part was created to assist Asians escaping Communist regimes. This act also enabled Japanese immigrants to come to the United States to reunite with their families. This legislation did much to reduce a source of persistent irritation in our relationship with Japan, who, by 1952 had become America’s major East Asian ally in the Cold War. The McCarren-Walter Act, was also (in large part) responsible for the creation of the Immigration and Naturalization service. The Bill was passed over President Truman’s veto who unsuccessfully attempted to eliminate the national bias quota section established by the
1924 Immigration Act noting this “. . . established an inhuman policy toward eligible foreign persons who may wish to emigrate to America.”98

Immigration Policy Since 1965

“A nation is formed by critical decisions, and, the American decision was to permit the entire world to enter almost without restrictions.”

Nathan Glazer and Daniel Patrick Moynihan

The Cold War became a referendum on two competing political systems: a closed Communist totalitarian system that opposed racism and an open democratic system that championed egalitarianism, but where racial and ethnic bias were tolerated and in some cases institutionalized. Although the western democracies all shared in the guilt of racism and inequality, the United States was particularly identified with bigotry and injustice in the eyes of the multietnic, nonwhite countries of the Third World whose hearts and minds in both systems were in competition. Important legislation was passed by the United States Congress proving to itself and the world that its government was committed to ideological and racial diversity and that discrimination and provincialism of the past were to be expunged as a matter of policy going forward. Begun as a mass movement among African-Americans and assisted by federal agencies, the Civil Rights Bill of 1964 and the Voting Rights Act of 1965 were passed, reinforcing the Fourteenth and Fifteenth Amendments to the Constitution codified a century earlier. This was followed by the Immigration Act of 1965 (the Celler Act) that contributed to this new awakening of democratic values that rejected racism and elitism.

Because the nationality quotas in the restrictive National Origins Act of 1924 were directed mainly at immigration from the countries of Eastern and South Central

99 Glazer and Moynihan, 22.
Europe, Congressmen representing constituents who had emigrated from these countries sought in vain over the next forty years to repeal this legislation. It was not until the presidency of Lyndon Johnson that their efforts were rewarded. Johnson felt that the country was ready for a more inclusive immigration policy and he lobbied the more conservative elements of Congress to pass the Immigration Act of 1965. He communicated to the Speaker of the House John McCormack, “There is no piece of legislation before the Congress that in terms of decency and equality is more demanding of passage than the immigration bill.”100 The terms of this bill raised the number of legal immigrants to 290,000 persons yearly, almost double the previous allotment, and allowed for 170,000 of these to emigrate from the eastern hemisphere. An annual quota of 20,000 immigrants per nation was established, and family unification provisions were broadened, which actually increased the number of immigrants above the stated quotas for many countries. Most significantly this new bill erased all previous exclusionary laws pertaining to Asians.101

Following the bill’s passage the pattern of immigration that resulted surprised both the framers of the legislation and the immigration experts. The President and Congress anticipated that the liberalization of the immigration law would have its greatest impact in western and southern European countries, expecting the bulk of the newest arrivals from Italy, Ireland, Germany and Greece. By the 1960s, however, Europe was enjoying a thriving economy which created favorable employment conditions and reduced the economic impetus for Europeans to leave their homes. Not only were these

100 Barone, 254-255.
101 Barone, 254-255.
countries able to retain their populations, but they actually attracted migrant “guest workers” from the less advantaged southern and near-eastern European countries where employment opportunities and wages were suboptimal. These circumstances accounted for the unexpected decrease in the immigration traffic from Europe, but this was more than offset by the surprisingly large influx of immigrants from southern and southeastern Asia.

United States immigration officials estimated that the Asian-Pacific triangle would supply about five thousand immigrants per year, which would “virtually disappear” after a few years. A shift in certain Asian economies, however, from small agriculture to heavy industry marginalized the small farm laborer who felt that better economic opportunities awaited in the United States. These changes also occurred at a time of political turmoil in Asia, including the hostilities in Korea, the war in Indo China, dissatisfaction with totalitarian regimes and the volatile status of Formosa (Taiwan), Hong Kong and India-Pakistan, all in the growing shadow of the new regional power, mainland China. This feeling of instability and fear occurring at a time that the United States passed its new inviting immigration law erased a good deal of the burden of uprooting themselves from their previous life, and thus augmented their exodus to the United States. During the instability in South Korea when the military was in charge of the government almost one half million of their population emigrated to the United States between the mid-1970s and the mid-1980s. After 1987 when the military government was deposed and replaced by a democratically-elected civilian government and with the improvement in the economy, immigration from Korea slowed dramatically.
Wartime political refugees comprised the lion’s share of immigrants from the Indo China wars following the French pullout in 1954 and the American redeployment after the Vietnam experience in 1975. These events triggered the flight of 957,000 Vietnamese, 183,000 Laotians, 128,000 Cambodians and 100,000 Thais to the United States in the 1970s, many of whom were ethnic Chinese. The bulk of Chinese immigrants, however, 840,000, arrived from China, Taiwan and Hong Kong between 1965 and 1997. Economic opportunity and political asylum also provided the catalyst for the emigration of over one million Filipinos to the United States during the fragile political situation that characterized the Marcos dictatorship. This largest group of Asians took advantage of their preferred immigration status to facilitate their access to the United States.102

Without a compelling reason to find “greener pastures” in the United States, emigration from Japan (and South Korea after 1987) basically was a non-factor. These countries, with their powerful economies and stable democratic regimes, often were unable to fill their allowed quota of immigrants. Japan accounted for slightly less than 100,000 immigrants to the U.S. between 1965 and 1997, a large contingent qualifying under the family unification program.103 Although Asians accounted for less than one percent of the U.S. population in the 1950s, by the early 21st Century they made up greater than four percent of Americans.

The Latino-Hispanics was the other main ethnic group to benefit by the 1965 Immigration Act. The family unification provisions and subsequent amnesty programs granted for illegal immigrants by revisions to the Bill in 1986 and 1995 enhanced their

102 Barone, 256.
103 Barone, 256.
totals going into the 21st Century. These measures inflated the number of legal immigrants from Mexico and other Latin American countries well in excess of the annual 20,000 quota per country. By 1978 Congress repealed the 170,000 limit granted for the Western Hemisphere to allow a greater allotment of immigrants from these countries. Again immigration officials grossly underestimated the huge influx of Latino immigrants that has occurred in the last half century. 104

The economic climate in the United States provided opportunities for the Hispanic workers who filled the low skilled and entry-level jobs as the existing domestic labor force climbed the vertical mobility ladder to the next work level which required greater education and advanced skills. 105 To a lesser degree political instability brought about by the bloody civil-insurgency wars in the Central American countries of San Salvador, Nicaragua and Guatemala escalated the flow of refugees seeking political asylum. The precedent of the United States providing a safe harbor for political refugees from this region was the tremendous upheaval created by Fidel Castro in 1959 when he assumed dictatorial power and declared Cuba a communist country allied with the Soviet Union. This precipitated surges of immigration to the U.S., totaling over one half million in the decade ending in 1970. An additional three hundred thousand Cubans came to America between 1970 and 1996. 106 Excepting Cuba, Latino immigration doubled in the 1970s over the previous decade to 153,000 annually, and again doubled to 300,000 per year in the 1980s, a rate that has remained constant into the new millennium. The 1986

104 Barone, 156.
106 Archdeacon, 209.
Amnesty Provisions provided for the addition of 1,236,000 Hispanic immigrants (mainly from Mexico), as this “addendum” to the law legalized the status of previously illegal aliens.\textsuperscript{107}

\textsuperscript{107} Barone, 160.
The Impact of the Immigration Act of 1965 on Higher and Medical Education

Of the major ethnic groups that have emigrated to the United States since the passage of the Immigration Act of 1965, the Latino community has yet to take full advantage of the American system of higher education. Although the Latinos’ rate of high school completion has been significantly greater in the United States than in their countries of origin, by the turn of the 20th Century it was only slightly more than one half. Naturally those Latino groups who resided in the U.S. for longer periods of time completed high school in greater numbers than those who were citizens of shorter durations. Graduation rates among Cubans and Puerto Ricans were 68% and 64% respectively, compared to only 48% for Mexicans. This trend continued into higher education with only 11% of Hispanics awarded college degrees, with Cubans holding 11%, Puerto Ricans 12% and Mexicans 7% compared with 25% of Whites and 15% of the African-Americans.\textsuperscript{108}

This tendency persisted at the graduate and professional school level albeit to a lesser degree since fewer numbers of Latinos graduated from college. This situation continues despite the option open to Hispanics of attending both secular and Catholic universities and medical schools, the latter offering preferential status for Hispanic students (95% Catholic) in the admission process. Although the numbers of Latino’s entering higher and professional education has slowly increased in the first decade of the 21st Century, it is the Asian immigrant experience that has overwhelmingly benefitted by the educational opportunities in their adopted country.

\textsuperscript{108} Barone, 169-170.
Immigrants from Asia in the post-1965 era were somewhat unusual in that they were no strangers to higher education. Twenty percent of Chinese immigrants in New York City in 1990 were already college graduates while an additional 16% had some college experience. Among Koreans and Filipinos the numbers were more impressive with 31% and 63% respectively having graduated from college while another 21% had taken some college courses. A large percentage of these immigrants reflected the recruitment of nurses during the acute nursing shortage that existed in the United States in the 1980s/1990s.

The first generation of Asian immigrant families, which also included large contingents from the subcontinent and Indochina, achieved greater academic success as they enrolled in institutions of higher learning in increasing numbers. With higher achievement in both the classroom and on standardized national tests, these students gained admission to the prestigious public academic schools in disproportion to their numbers where they lived. In New York City 50% of the students at the select Stuyvesant High School, 40% at the Bronx High School of Science, and one third of the students at Brooklyn Technical High School were of Asian ancestry in a city where they made up only 10% of the public school students. This phenomenon was not limited to New York City, as this pattern was repeated across the nation where there were large Asian communities, e.g. Lowell High School in San Francisco and Thomas Jefferson High School in Alexandria, Virginia.

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109 Barone, 265.
110 Barone, 266.
By 1990 almost 40% of Asian Americans completed college compared to the national average of 25%. This high proportion continued despite being subjected to a quota system for the past two decades. Instead of a restrictive quota, the type which was intended to limit Jewish enrollment, the Asian-American students have experienced a “benign” or “soft quota,” a selective admission policy designed to create opportunities for the underrepresented minorities in higher education, i.e. Latinos, Afro-Americans, and Native Americans. Despite this “progressive” quota system, by 1998 students of Asian ancestry still accounted for a significant percentage of students at such elite universities as Harvard (19%), MIT (28%), Stanford (22%), the University of California at Berkeley (39%) and UCLA (38%). The flagship University of Michigan enrolled 10% Asian Americans in a state with fewer than 2.5% Asians.112 Were it not for these “benign quotas,” it has been estimated that 70% fewer applicants of underrepresented minorities would have been selected by the “first tier” institutions.113

At the graduate school level students of Asian ancestry are also amply represented, especially in the business and science-technology areas, but their presence in the field of medical education has been exceptional. By 2002 Asians accounted for 18.1% of U.S. medical school graduates despite the fact that they comprised only 3.6% of the national population.114 Two years later their matriculation rate increased to 21%. This upward trend of the enrollment/graduation rate for Asian-American medical students has become a reality since 1980 when Asians comprised only four percent of the White total, and by

112 Barone, 267.
2004 their numbers had increased almost ten-fold.\textsuperscript{115} Predictably their academic performance favored math and science over language skills when compared to their medical school white cohort group. Higher scores on both the SAT (Scholastic Aptitude Test) and MCAT (Medical College Admission Test) quantitative and science subtests were recorded by the Asian-American students compared to their white counterparts. The latter group, however, scored significantly higher on the English and reading subtests not only on these examinations, but also on all three parts of the National Board of Medical Examiners testing (completed during the last two years of medical school).\textsuperscript{116} This is understandable and reflected the Asian-American student’s upbringing in bilingual households and communities where English is a second language.

In 1974-75 1,217 Asians (2.9% of all applicants) applied to medical schools of which 385 were accepted making up 2.7% of the incoming freshman class. That same year 34,785 whites applied (81.6% of all applicants) of which 12,441 were accepted to comprise 81.6% of the first-year medical students. By 2001-2002 these figures changed considerably as 6,794 Asians made up 19.4% of all applicants of which 51% were accepted to make up 21% of the class. That same year 11,060 whites were accepted (51.7% of applicants) to make up 61% of the class.\textsuperscript{117} In future classes statistical evaluation of race-ethnicity data re: medical school applications and admissions changed somewhat as applicants were offered the option of reporting both their race and ethnicity alone or in combination with another race/ethnicity as the second and third generations of


\textsuperscript{117} AAMC Data, p. 3, supplied by Collins Mikesell.
Asian-American students became ethnically more heterogeneous. Despite these “combinations” of nationality and racial groups, the overall effect has been minimal (about 10%) with the Asian-white mixture most common. Of the total medical school class matriculating in 2012, approximately 24% were Asian or “in combination” while 62% were classified as white.

Black, Native American and Mexican American (Chicano) application and admission rates to medical school had only marginally increased in the period 1974 to 2001. African-American and Native American enrollment had remained fairly static at 7% and 0.7% respectively. During this period Chicano medical school enrollment almost tripled although the percentage remains low at 2.3%.\textsuperscript{118} This growth has been very gradual despite the marked increase of the Mexican-American population in the U.S. and the initiatives of medical schools through affirmative action and benign quotas to expand Latino participation in medical higher education.

\textsuperscript{118} AAMC Data, supplied by Collins Mikesell.
The major impact of the post-1965 Asian immigration to the United States has been in the western and coastal states although a sizable number of Asians have settled in the larger urban centers of the east and Midwest. Nationwide the first and second generations of these immigrant families have enrolled in medical schools in disproportionately higher numbers especially in the West Coast universities. Although making up only 2.3% of North Carolina’s population, this national trend has gained traction in the Tar Heel State as students of Asian ancestry have applied to and have been accepted at the state’s four medical institutions in increasing numbers in the past two decades.

The select, private Duke University School of Medicine (DUSM) demonstrates this phenomenon most strikingly, where prior to 1965 Asian-American enrollment was minimal. By 1992-1993, however, 13% of the medical school class was of Asian ancestry and this surged to almost 29% in 2012-2013.\(^{119}\) This was particularly interesting as DUSM was identified as one which practiced an ethnic (Jewish) quota system in the past.

The private Bowman Gray School of Medicine of Wake Forest University (BGSM) followed a somewhat similar trajectory, although not as steep as the Duke experience. Prior to 1965 the number of Asian medical students at BGSM was negligible but between 2005 and 2012, the Asian American presence ranged between 9.5 and 15%.\(^{120}\) Since 2009 the medical school has no longer received a capitation fee from the

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\(^{119}\) Duke University Data from the Office of Admissions.

\(^{120}\) BGSM Data from the Office of the Registrar, Sonja Vientos.
state, therefore it has modified its policy of giving priority to admitting in-state North Carolina students, which now account for less than two-thirds of matriculating students. This change has made it possible to admit higher numbers of out-of-state Asian students.

In the past decade the BGSM has also initiated a policy of admitting greater numbers of underrepresented minorities, during which time African-American and Hispanic enrollment has averaged ten and four percent respectively, both slightly higher than the national average.

The North Carolina public medical schools, the University of North Carolina School of Medicine (UNCSM) at Chapel Hill and the Brody Medical School of East Carolina University in Greenville receive the bulk of their funding from the state and therefore have a mission and responsibility not completely shared by the private institutions. The public medical schools are obliged to educate students mainly from the state of North Carolina and the Brody School of Medicine has the added goal of graduating physicians who will provide medical care to the underserved areas and populations of eastern North Carolina, in particular the Hispanic, Black and Native American communities. The ethnic balance of ECU’s medical school’s classes reflect this commitment, noting since 1991 African-Americans have averaged fifteen percent enrollment, while Native Americans have averaged about three percent. The percentage of Hispanic doctors graduated from the Brody Medical School of ECU is less than two percent, commensurate with the small but growing migration of Hispanics to eastern North Carolina. The number of Asian-American medical students however has almost doubled since the 1990s, from 5.7% to 10% with an upward trend in the past three
Although these numbers are not as dramatic as DUMS, East Carolina University’s commitment to admit in-state students and underrepresented minorities reflect these modest increases.

The University of North Carolina School of Medicine practices an admission policy similar to that of the Brody Medical School of ECU, mandating a preference for in-state students and underrepresented minorities. Since 1989 the UNCSM has maintained an African-American enrollment between 9 and 16%. Although the percentage of Hispanic medical students has been considerably lower (in a state with 8% Hispanics), it had actually doubled by 2012 to the 3% range. The Asian-American enrollment (in a state with 2.3% Asians) since 1999 has been in the 12 to 13% range, almost a four-fold increase since 1989.

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121 ECUSM Data from the Office of Admissions, Dr. Jim Pedan.

122 UNCSM Data, Office of Admissions, Jim O’Neill, Medical Education IT.
Immigration has not only influenced the ethnic composition of medical schools, but has also made ripples in practice patterns in the United States. Foreign medical graduates who have emigrated and taken up citizenship in the United States have been performing an important and unique function in America’s health care delivery system. Previously known as FMGs, they are now designated IMGS (International Medical Graduates), although this identity is somewhat misleading, as between two thirds to three fourths of these IMGS are American citizens who obtained their medical education abroad (mainly in the Caribbean schools of Grenada and Dominica). The actual immigrant segment of which India/Pakistan accounts for the largest contingent began arriving in the United States in the late 1960s. This particular group of immigrant-physicians has become indispensable as they have made a difference while providing primary medical care to underserved and rural areas in the United States. This is in contrast to U.S. medical graduates (USMG) of South Asian descent who opt for subspecialty training programs and careers that bring them eventually to medium and large cities. Although the number of South Asian IMGs in the United States is comparatively small, less than one percent nationwide (two percent in California), there are few graduating physicians from U.S. medical schools who have demonstrated a willingness to replace them as they retire, exposing a serious deficiency in our health care system. 123 Most troubling is a recent (2005) survey of 2,000 physicians in Massachusetts

regarding workplace discrimination. Over 60% of respondents reported that discrimination directed at IMGs was a significant problem, the very group that occupies such an important niche in underserved rural America.¹²⁴

Contrasting the Jewish and Asian Experience: The Overrepresented Minorities

“In the 1920s, people asked: will Harvard still be Harvard with so many Jews? Today we ask: will Harvard be Harvard with so many Asians?” Carolyn Chen125

The two great waves of immigration to the United States, 1880 to 1914, and 1965 to the present have had an extraordinary impact on the ethnic composition of American medical schools and the physician community as a whole. How the medical educational establishment dealt with these immigrant groups in the past and how they address similar issues today demonstrate who we were and how we have evolved as a country. Although all of the ethnic groups and nationalities who arrived on American shores eventually recognized education as their springboard to the American Dream, the first and second generations of Jewish immigrants were first to take advantage of these opportunities, especially in New York and the large cities of the north. Beginning in the last decade of the 19th Century and going into the early 20th Century, the immigrant children of Russian-Polish Jews entered high school, college and post graduate professional schools in unprecedented numbers. The tide of Jewish immigration fortuitously coincided with the expansion of American higher education as college enrollments increased fivefold compared to the population between 1890 and 1925.126 Jewish students were initially accepted on the basis of merit and without reservation but when their numbers reached a critical mass after a period of unchecked expansion into the halls of higher education, barriers were constructed to impede their progress; the selective admission and quota

125 Chen, 43.
126 Steinberg, 11.
system. This was particularly practiced by the elite colleges and universities of the northeast and especially in the field of medical education. No other immigrant group at the time felt the sting of this restrictive policy except Italian Catholics and to a much lesser degree. This system remained almost completely intact for forty years until the 1960s.

The Asian immigrant experience in the latter part of the 20th Century however was quite different from that of the Jews in accessing a college and medical school education. Instead of their qualified students being met with quotas and restrictions by university and medical school officials the Asian immigrant students have been judged on the basis of their academic preparation and their ability to successfully complete their degree programs. Social and political changes were largely responsible for this reception including the recognition of human and civil rights in the post World War II era that have been the defining element of citizenship in the United States, codified in the Constitution and United Nations Charter. National attention focused on the eradification of discriminatory policies that had hitherto been tolerated and in many cases allowed to flourish within the legal apparatus. The outrage of racial, ethnic and religious inequality and what it fostered economically, socially and psychologically challenged the conscience of a country. Identifying educational opportunity as an area that required reforms, fair practices legislation was enacted on a national scale to eliminate bias and inequality inherent in the quota system. The Asian community was able to reap the rewards of such legislation which actually predated their American experience by almost two decades. Although relatively quiet and non-committal during the high-tide of the medical school quota system, in 1982 the AAMC released its policy statement
confirming that discriminatory policies with regard to race, creed, color or national origin have no place in American medical schools and no relevance to the proper selection of candidates.\footnote{Davis Gilman Johnson, \textit{Physicians in the Making} (Washington, D.C.: AAMC Jossey-Bass Publishers, 1983), 89.} Today there is also a favorable climate on campuses to embrace diversity, not necessarily as a function of university policy or legal precedents, but rather as a positive feature of American life. The columnist Peggy Noonan, in a recent article in the \textit{Wall Street Journal} supporting immigration, recognized an atmosphere of inclusiveness in the United States, “. . . American friendliness, openness, and lack of – what to call it? The old hatreds. They dissipate here.”\footnote{Peggy Noonan, “Is That Allowed? It is Here.” \textit{The Wall Street Journal}, 7-8 July 2012, sec. A. 13.}
The Bakke Decision and Backlash: Are the Asians the New Jews?

“But it is argued that positions for which high achievement levels are necessary, such as scholarship, the arts, medicine... should not be subject to quotas and special preferred policies.” Seymour Martin Lipsett\textsuperscript{129}

“Reverse discrimination is a misnomer; it is discrimination.”

Benjamin R. Epstein and Arnold Foster\textsuperscript{130}

Despite the positive reception of the “new immigrant” into the mainstream of higher and medical education in the post-1965 era, recent developments warn of a rebirth of a quota policy, but the potential victims have now become the Asian-American student. In 1978 the Supreme Court handed down the Bakke Decision, a case which questioned the constitutionality of a medical school’s decision to create a quota of places in each class for minority students. The case involved Allan Bakke, a qualified medical school applicant who was refused admission to the University of California Medical School at Davis because of his race (Caucasian) to favor less qualified minority “set asides.” Although the Court affirmed that race-based quotas and “set asides” were unconstitutional and violated Title VI of the Civil Rights Act of 1964, they also confirmed that race could be considered as a criterion in the admission process to create diversity. Although Bakke was eventually admitted to medical school, Jewish groups represented by the Anti-Defamation League submitted a brief as \textit{amici curiae} maintaining that such a quota policy discriminates against applicants, thereby violating

\textsuperscript{129} Lipsett, 124.

\textsuperscript{130} Epstein and Foster, 31.
the equal protection clause of the Fourteenth Amendment.\textsuperscript{131} The Asian American community is now concerned that its members have become the target of such a “reverse discrimination” policy.\textsuperscript{132}

Data collected for the past several years revealed that elite colleges and medical schools have admitted the underrepresented minority student in preference to the “overrepresented” minority student (the Asians) despite the superior and often outstanding academic qualifications of the latter. This action, ironically had its origins in the 1970s/1980s when federal government affirmative action programs assisted “Asians or Pacific Islanders. . . persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands” to access greater opportunities in higher education. As a result Asians benefitted and their enrollment soared at the elite California (State) universities at Berkeley and UCLA. By 1984 they accounted for a quarter of the freshmen classes at these schools, in a state whose Asian population was about 12%. In the years to follow Asians were no longer considered an underrepresented minority, therefore not qualifying for affirmative action programs. By 1989 both UCLA and the University of California were investigated by the federal government for practicing Asian quotas, and, in fact, some minor infractions were identified at UCLA. In a similar situation an investigation by the U.S. Department of Education of Harvard University’s admission practices in 1990 found that better qualified

\textsuperscript{131} Peter Charles Hofler, William James Hull Hoffler and N.E.H. Hull, \textit{The Supreme Court: An Essential History} (Lawrence, Ks: University Press of Kansas, 2007), 379-381.

\textsuperscript{132} Carolyn Chen, 43.
Asian-Americans were admitted “at a significantly lower rate than white applicants,” 13.2% vs. 17.9%, from 1979 to 1988.\textsuperscript{133} Although Asian-American students comprise 12 to 18% of Ivy League college enrollment there are reservations among some (white) alumni, administrators and even parents who are concerned that these elite campuses are becoming “too Asian.”\textsuperscript{134} This phase is chillingly all too familiar when similar fears were entertained by these same institutions becoming “too Jewish” in the 1920s. Worrisome also is the return of the language of ethnic stereotypes that Jewish students were subject during the hey-day of Jewish quotas that are now being applied to the Asian-American student “. . . another textureless math grind. . .quiet/shy. . . hard worker. . . quasi-robots programmed by their parents.”\textsuperscript{135} In the era of political correctness certainly no college administrator would use the term “greasy grind” as one Yale dean in 1918 referred to the typical Jewish student, but the typecast is that Asian-American students are now regarded as the “new Jews, inheriting the mantle of the most disenfranchised group in college admissions.”\textsuperscript{136} An interesting side-note is that not all Asian Americans perform academically at such high levels and those from Laos, Cambodia and the Philippines who also comprise the poorer, less educated Asian families have lower academic performances, and may, in fact, qualify for affirmative action denied them because of their Asian classification.\textsuperscript{137}


\textsuperscript{134} Chen, 43.

\textsuperscript{135} Golden, 201.

\textsuperscript{136} Golden, 199.

\textsuperscript{137} Golden, 201-204.
Fortunately the “preferences of privilege” installed by the elite colleges that are noticeably lacking among Asian applicants including prioritized places for legacies, athletes, wealthy donor’s and faculty children, and most recently underrepresented minorities have only minimally impacted medical school admission policy. It has been said that college is a community but medical school is a meritocracy.\textsuperscript{138} The education of physicians is too important a task in the twenty-first century not to offer the best and brightest candidates the opportunity to attend its medical schools. The era of denying those who are academically qualified a place in medical school is no longer acceptable nor desirable, and represents a waste and poor allocation of limited resources. The regrettable practices of selective admission and quota systems that had been based on race, gender, ethnicity, religion and nationality have mercifully been denounced as illegal and undemocratic and no longer (should) present obstacles to those pursuing the study of medicine.

It is important, even a priority, that qualified underrepresented minorities including the economically-disadvantaged student be given the opportunity to obtain a medical education. With the limited availability of places in medical school classes, it is unfair that the burden of securing admission for these students should fall disproportionately on the Asian-Americas or any other group because of their belonging to an “overrepresented minority.” This implies a racial quota which “. . . cannot be benign. It must always be malignant, malignant because it defies the constitutional proclamation of equal protection of the laws.”\textsuperscript{139} Justice William O. Douglas succinctly

\textsuperscript{138} Dr. Wallace Wu, Professor Emeritus, Bowman Gray School of Medicine, Conversation with author, February 22, 2013.

\textsuperscript{139} Brief Amici Curiae of Anti-Defamation League of B’NAI B’RITH October Term, 1977, 19.
summarized this in the De Funis V. Odegaard race discrimination case. “There is no constitutional right for any race to be preferred. Whatever his race, he had a constitutional right to have his application considered on its individual merits in a racially neutral manner.”

The students spawned by the immigrant families now enjoy equal opportunities to succeed within our medical educational system. The medical profession has uniquely thrived on the abilities of immigrant groups who have provided the practitioners, researchers and teachers from the time medicine became an evidence-based discipline at the turn of the last century to the technological breakthroughs of the new millennium. Hopefully medical education will continue to provide a vehicle for those with talent and drive to achieve social, economic, and intellectual mobility, the pursuit of which the American immigrant has recognized since entering the Golden Doors.

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140 Ibid, 14.
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Curriculum Vitae

Michael H. Rubin

Born: August 10, 1944

Marital Status: Married with three children

Business Address: Salem Gastroenterology Associates, P.A.
1830 South Hawthorne Road
Winston-Salem, NC 27103

Salem Endoscopy Center
875 Bethesda Road
Winston-Salem, NC 27103

336.765.0463
Fax: 336.768.9452

Education: B.S. in Biology, University of Pennsylvania, 1965
M.S. in Biology, University of Pennsylvania, 1966
M.D., Medical College Virginia, 1970
Candidate for Master of Arts in Liberal Studies (MALS),
Wake Forest University, 2013

Training and Academic Positions:
Spring/Summer of 1966, Instructor in Biology, University of Pennsylvania
Summer of 1967, Clerkship in Pathology, Cedar-Sinai Medical Center,
Los Angeles, California
Summer of 1968, Clerkship in Pathology, Mary Hitchcock Clinic,
Dartmouth Medical School, Hanover, New Hampshire
June 1970 –June 1971, Internship (Medicine)
University of Vermont Medical Center, Burlington, Vermont
June 1971 –June 1973, Military Service
June 1973 –July 1975, Assistant Resident in Internal Medicine,
Vanderbilt University Hospital, Nashville, Tennessee
July 1975–July 1976, Clinical Research Fellow, Liver Unit
Vanderbilt University Hospital, Nashville, Tennessee
1977–1979, Clinical Instructor, Gastroenterology,
Bowman Gray School of Medicine, Winston-Salem, North Carolina

Board Certification: American Board of Internal Medicine, June 1976
American Board of Internal Medicine, Gastroenterology, November 10, 1981

Employment History: Forsyth Medical Specialists, August 1977–March 1979
Salem Gastroenterology Associates, P.A., March 1979–Present

Honors: Smith and Nephew Fellowship, Special Award, 1975–1976
American Academy of Family Physicians, Active Teacher Award, 1978

Professional Organizations: Fellow, American College of Physicians
Member, American Association for Study of Liver Diseases
Fellow, American College of Gastroenterology
Member, American Society of Gastrointestinal Endoscopy

Positions Held: Joint Administrative Board, Forsyth Medical Center, 2004–2006
Credential Committee, Forsyth Medical Center, 2002–2005
President, Forsyth Medical Center, Hospital Staff, July 1, 1999–June 30, 2000
Vice President, Forsyth Medical Center, Hospital Staff, July 1, 1998–June 30, 1999
Division Director, Department of Medicine, Forsyth Memorial Hospital/Medical Park Hospital, June 1994–June 1997
Ad Hoc Committee on Communications, American Society of Gastroenterology/Endoscopy, 1993–1994
Forsyth County Medical Society, At Large Executive Committee, 1991–1993
Chief, Section of Gastroenterology, Forsyth Memorial Hospital and Medical Park Hospital, June 1991–June 1994

Research Interests:
Platelet Function in Liver Disease
Artificial Support Systems in Therapy of Hepatic Encephalopathy

Publications:

2. Rubin, M.H., Weston, M.J., Langley, P.G., White, Y., and Williams, R., Platelet Function in Chronic Liver Disease: Relationship to Disease Severity (In Manuscript) (Accepted for Publication, American Journal of Digestive Diseases, November 1978)


11. Rubin, M.H., Ward, D.M. and painter, J.C., Fulminant Hepatic Failure Due to Genital Herpes in a Healthy Individual. Accepted for Publication, October 19, 1984 for JAMA.