



A History of the
Josiah Macy Jr. Foundation's
Grantmaking to Increase
Diversity, Equity, and Belonging
in the Health Professions

PART 2

**Advancing Historically
Marginalized and
Underrepresented
Populations in Health Care**

As described in Part 1 of this paper, the Josiah Macy Jr. Foundation's focus on grantmaking to improve health and health care has evolved quite a bit over the nearly 90 years since its founding in 1930. In the Foundation's early years, it primarily supported cutting-edge medical research and the dissemination of research findings to physicians. Today, Macy is the only private foundation dedicated to advancing the education of America's health professionals, including the training of physicians, nurses, pharmacists, social workers, and other health professionals together in teams. The Foundation funds research with an eye toward boosting the careers of talented young faculty members from diverse backgrounds whose research generally examines and evaluates innovations and best practices in health professions pedagogy.

Among the most crucial and challenging pedagogical concepts that today's health professions schools are working hard to integrate into their teaching and learning environments are those of diversity, equity, and inclusion. Diversity refers to valuing the wide variety of human differences that make every individual unique. Equity means that everyone should have a fair opportunity to attain their full potential and, more pragmatically, no one should be disadvantaged from achieving this potential if it can be avoided. And inclusion refers to ensuring equitable environments in which everyone is welcome and treated with respect.

The focus in health professions education on diversity, equity, and inclusion is the result of

many inter-related factors, including the need to: 1) eliminate health disparities, address the social determinants of health, and improve health outcomes for underrepresented and underserved populations; 2) create a more culturally competent health care workforce as the U.S. population lives longer with more chronic illness and grows increasingly diverse; and 3) ensure that the nation's health professions schools attract the highest quality students from the widest and deepest pool of potential matriculants possible. It also is the right thing to do, to ensure equitable opportunities for everyone, but particularly for those to whom such opportunities have been historically denied. Not only that, but there exists a social contract between health care institutions/practitioners and the populations they serve that must be honored.

Given the focus on diversity, equity, and inclusion among health professions educators, it stands to reason that today's Macy Foundation, as a funder of innovations in health professions education, is interested in the topic as well. In fact, the Foundation's new strategic plan, launched in 2020, states: "We must ensure that everyone who receives care and those who learn, teach, and work in clinical environments are treated equitably. Systemic inequities that reduce career satisfaction and limit advancement opportunities for health professionals from historically underrepresented communities, including people of color, women, people with disabilities, the LGBTQ+ [lesbian, gay, bisexual, transgender, queer] community, members of some religious groups, and individuals from low-income households need solutions."

Along with looking toward future funding strategies, however, the Macy Foundation also commissioned this essay to provide a look backward at its grantmaking efforts relevant to diversity in the health professions over the decades. Accordingly, a review of the Josiah Macy Jr. Foundation's archives, performed in summer 2019, explored its grantmaking with respect to women and other historically marginalized populations. A previous essay—Part 1—provided an overview of the Foundation's historical grantmaking efforts related to women. That paper concluded that Mrs. Kate Macy Ladd and the Foundation she created were and are supportive of both women's health care and women in health care. This essay—Part 2—continues that historical review and looks at the Foundation's efforts with respect to advancing other underrepresented* populations in health care.

Macy's first organized efforts to support diversity in health care, in the 1960s and 70s, centered primarily around increasing the number of and supporting the careers of Black men and women in U.S. medical schools and in medicine, with some efforts also seeking to increase the numbers of enrollees

**This paper was written in two parts by a person who identifies as white, heterosexual, cisgender, able-bodied, upper middle class, and atheist—among other traits. Corrections are welcome, particularly if this attempt to write about historically marginalized population groups to which the author does not belong raise any concerns with readers.*



with Latinx (then called Hispanic) or American Indian backgrounds. Such efforts became popular with health-focused foundations in the 1960s and 1970s, when the Civil Rights Movement featured prominently on the nation's social and political agendas. The philanthropic efforts coalesced with those of the Association of American Medical Colleges (AAMC) and several other health care associations, which in 1969 announced a goal of increasing "minority" enrollment in medical schools from 2.8% in 1970–71 to 12% in 1975–76.¹

With Black, Latinx, Asian American, and American Indian populations expected to comprise the majority of the total U.S. population by 2045, the historical concept of minorities is on its way out. Today's historically marginalized, underrepresented populations are inclusive of the many personal and social identities that make people unique. These can include race, ethnicity, nationality, gender, sexual orientation, age, religion, physical ability, socioeconomic status, and much more—those identities listed here happen to be the most common traits on which data are often, or at least sometimes, collected (by the U.S. Census, for example). Even patients with certain health conditions have found themselves marginalized at various times, such as HIV-positive patients in the 1980s. Not only that, but today we talk about Dr. Kimberlé Crenshaw's concept of "intersectionality," which, as defined in Part 1 according to Merriam-Webster dictionary, is: "the complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups." Today, the goal is to teach health professionals to value diversity, ensure equity, and practice inclusion in order to reduce the negative effects of all types of bias and discrimination in health care.

As outlined in this essay, Macy's grantmaking relevant to historically underrepresented populations in the health professions follows a pattern similar to its grantmaking relevant to women, as described in Part 1. There is evidence that Kate Macy Ladd, who endowed the Josiah Macy Jr. Foundation in 1930, was concerned about the health and well-being of poor families, including Black and immigrant Americans, and sometimes directed her own charitable giving toward efforts focused on them, as she did with efforts focused on women and children.

However, while women were sometimes the beneficiaries of early medical research grants awarded by the Foundation, there is no evidence to suggest that this was also the case for Black or immigrant researchers. It was not until the 1960s and 1970s that the Foundation became concerned with supporting "minorities" in medicine. However, while the Foundation's efforts focused on women have ebbed and flowed since the 1960s, it has maintained a somewhat more consistent focus

on advancing marginalized population groups in the health professions since that time.

Kate Macy Ladd: A Philanthropist in the Quaker Tradition

Even though the Macy Foundation, in the various identity materials it has published over the decades, has never suggested that Kate Macy Ladd may have been a suffragette or even held liberal or progressive ideas, it was relatively easy, in Part 1, to argue that she leaned in those directions—though those specific terms would not have been applied to her. Her biographer clearly viewed her as an empathic, strong-minded, and independent thinker, presenting her as a "woman of her time" in the biography *Finding Kate: The Unlikely Journey of 20th Century Healthcare Advocate Kate Macy Ladd*. The biographer suggested that Mrs. Ladd was about a decade older than the generation of women who became suffragettes and liberal humanitarians; instead, Mrs. Ladd demonstrated these ideals in ways that were in keeping with the boundaries of her social class and era.

The case for her support of underrepresented populations is harder to make than the case for her support of women, but there is some evidence suggesting she aspired to egalitarian philanthropy. First, many generations of the Macy family were members of the Religious Society of Friends, and Kate was raised in the religion, which espoused equality among its fundamental tenets. What exactly "equality" meant to the Quakers of Kate's time is debatable—it likely depended on many factors—but certainly Quakers were closely associated with the Abolitionist movement and efforts to help freed slaves following the American Civil War. "After the 1750s, Quakers actively engaged in attempting to sway public opinion in Britain and America against the slave trade and slavery in general. At the same time, Quakers became actively involved in the economic, educational, and political well-being of the formerly enslaved."²

This is not to overstate Kate's views of Black people in America, which are unknown to us, but simply to suggest that she would have been exposed to more progressive views of human equality through her family's religion, which also instilled in her a commitment to charity and a belief in the power of education for everyone.³ Second, with respect to her charitable giving in support of marginalized people, Kate's brother, V. Everit Macy, "was an early promoter of the Hampton Institute" (an historically Black college known today as Hampton University) "and Tuskegee Normal and Industrial Institute" (co-founded as a teacher's college for Black



people by Booker T. Washington, a former Hampton teacher, and known today as Tuskegee University), “and he induced the Ladds to financially supporting those institutions as well.”² Unfortunately, this is the only reference found to Kate having supported institutions specifically intended to benefit Black people in America. This does not mean more was not done, only that, if so, it was not uncovered in the archived materials reviewed for this paper.

If we look beyond race and consider marginalized populations of Kate’s era more broadly—to include, for example, New York City’s poor, immigrant families—her philanthropy also extended to them. She was an ardent supporter of the work pioneered by Lillian Wald, who championed health care as a right for everyone, including immigrants and the poor, and who essentially founded community-based nursing. “In the early twentieth century ... Kate was drawn to support the work of public nursing advocate Lillian Wald, who had been ministering among the poor of New York since 1893 ... Miss Wald’s efforts spawned what became known as The Henry Street Settlement and the Visiting Nurse Service of New York City (VNS).”² Ms. Wald’s humanitarian work made her famous nationwide and spawned many similar visiting nurse associations around the country that provided home- and community-based care for the very poor in their communities.

According to her biographer, Kate also became a passionate benefactor of the Visiting Nurse Association (VNA) of Somerset Hills, near her country estate in New Jersey. “Although the Somerset Hills were known to be an elite enclave, the vicinity was also home to a sizable population of immigrant families, those whose toil made it possible to maintain the area’s large estates and the affluent residents’ luxurious lifestyles.” Kate joined the VNA board and hosted meetings at her estate, including bringing Ms. Wald—who had become a close, personal friend—to present to the group, while the Ladds also made generous financial gifts to the organization. Kate was particularly supportive of the VNA’s efforts to provide fresh, clean milk to poor families with children and to make health care available to poor children in schools. Kate remained a devoted supporter of both Ms. Wald’s work and the work of the New York VNS and the Somerset Hills VNA for the remainder of her life.

A Thread Introduced: Minorities in Macy’s Middle Years (1960s–1990s)

As noted in Part 1, the Macy Foundation showed early signs of supporting the research of women physicians as well as research into health topics that affected women. When the Foundation was

launched in 1930, women were enjoying some visibility in medicine, the numbers of women in medical schools and practicing medicine having increased in the late 1800s and early 1900s. But that trend subsided by the 1940s and women researchers all but disappeared from Macy’s grantmaking records for a couple of decades. Those same archival materials, unfortunately, make no mention of grants made to researchers from other underrepresented populations in the Foundation’s first 30 years or so of operation. While women grantees were introduced into the Macy Foundation’s fabric from the very beginning, the thread representing “minority” grantees was not introduced until the Foundation’s middle years.

This is not to say that no such grants were made by Macy early on, but if they were, they have not been remarked upon over the years. The women grantees in the Foundation’s early years were recognized in the archival materials that capture minutes from board meetings over the years. For example, early board books and other materials include quotes or references made by board members to the work of certain women grantees. If not for these notes, it would have been difficult to identify the grantees as women because they were often named in lists of grants awarded only by their first initials and last names. Not only that, but it looks like the earliest grants to support women’s research often went to their male department heads, which also made it difficult to identify the women who were doing the funded research. These same challenges made it difficult to identify researchers from other population groups as well, with the difference being that no quotes or other references to race, ethnicity, etc., were captured in the board meeting minutes or other archival materials.

While no evidence was found in the early Macy board materials of specific grants made to minority researchers, a later Macy report did make a brief reference to philanthropic support for Blacks in medicine in the first half of 20th century America. A 1967 conference report, published by Macy in 1968, suggests that the Rockefeller Foundation was one of the only philanthropies involved with funding historically Black medical schools prior to the 1960s: “Until recently, the Rockefeller Foundation was virtually the only philanthropic organization to do anything significant about the problems of health and [Black American] education in the South.”⁴ Of course, funding for historically Black medical schools does not preclude funding for individual Black researchers at any number of medical schools, but this single funding reference, in combination with a lack of other evidence that such grants were given, suggests that it was unlikely.

The Macy conference report, which was based on the Foundation’s first conference on the topic of Black Americans in medicine in 1967, notes that between 1916–1960, Rockefeller had given more than \$8.6 million to Meharry Medical College in Nashville—the only medical and dental school to



admit Black students only. And from 1926–1936, it gave more than \$500,000 to another historically Black school, Howard University Medical School in Washington, D.C. Rockefeller also funded medical residency programs and fellowships for Black medical students and also supported undergraduate education programs in both the sciences and humanities for Black students at a variety of schools—and some later programs for Mexican American students at two California schools.

These Rockefeller programs as well as similar programs, mostly funded in the late 1950s and early 1960s by Carnegie Corporation, the Julius Rosenwald Fund, Alfred P. Sloan Foundation, and a few others, were explored by the Macy Foundation during its 1967 conference focused on the need for more Black American medical students and practicing physicians.³

The Bowers Presidency

As described in Part 1 of this paper, Dr. John Bowers, who had briefly been on staff at the Rockefeller Foundation, had become president of the Macy Foundation in 1965. That was the same year the United States Congress enacted Medicaid and Medicare, creating public health insurance for millions and an urgent need for more physicians, particularly those willing to serve historically marginalized and low-income populations. The Medicaid and Medicare legislation had followed on the heels of federal legislation aimed at expanding enrollment in the nation's medical schools. As a result of this legislative activity as well as demonstrated need for better access to health care in communities of color, many foundations at the time, including Macy, became interested in increasing the numbers of Black Americans attending and graduating from medical school. In the mid-1960s, Blacks comprised 11% of the general population but only two percent of the physician population. Also at that time, only six percent of college-age Black persons attended college, and more than half of them were at historically Black institutions where the drop-out rate averaged more than 50%.³

In his foreword introducing the 1967 conference report, Bowers wrote: "Today, all of the medical schools in the South as well as other parts of the United States, admit and are seeking [Black] students. But there are many problems—among them identification and recruitment in high school and college, guidance, preparation, admission, and financing . . . Although the problems admittedly are complex, there is an urgent need for solutions or for pilot programs that will point the way toward solutions."³

The conference report went on to recommend both short- and long-range educational and training programs that should be funded and supported by both philanthropy and the federal government.

Some of the short-range measures that were recommended included development of: a national scholarship program for Black college students interested in medicine; liaisons who coordinate academic requirements between historically Black colleges, universities, and medical schools; more rigorous science courses at historically Black colleges and universities; and support programs for Black students attending medical schools where they are in the minority.³

Long-range solutions recommended by the conferees were less practical and more aspirational: "The problem of getting more [Blacks] into the medical profession cannot, in the long run, be separated from the problem of educating more [Blacks] and educating them well. We are talking not only about improving curriculum, faculty, and facilities at all [historically Black] colleges, but about improving education and educational systems in the high schools and elementary schools attended by [Black] students all over the country...as well as support of both potentially gifted students and for less gifted students who have good potential."³

The conference report concluded with a call to action: "Change must come from all corners; it must involve everyone...[It] means federal financial support to educate every [Black American] to the limit of his individual capacity. It means vast social, cultural, and economic programs. The foundations can launch programs to point the way, in anticipation of the end of the war in Vietnam. When that war ends, this is the front we must fight on."³

Dr. Bowers took this charge to heart. According to a 2012 published overview of Macy's history: "The signature program during the Bowers era was the Minority Groups for Medicine Program. Bowers initiated attempts by the Macy Foundation to address two interrelated problems: the lack of adequate health care services provided in predominantly Black communities, and the socioeconomic barriers that deterred Black students from pursuing careers in medicine...During the Bowers era the Macy Foundation assumed a leadership role in the effort to increase the number of Blacks and other underrepresented minorities practicing medicine..."⁵

Aside from the 1967 conference, which was followed in 1968 by two more Macy conferences on the topic of increasing the numbers of Black students in medical schools, Bowers also instituted a Macy-funded program at Haverford College to better prepare "disadvantaged" students for success in medical school. The Post-Baccalaureate Premedical Fellowship Program, though not technically limited exclusively to Black students, "demonstrated to admissions officers of predominantly white medical schools that Black students could become competitive candidates for admission, provided they had adequate preparation and support."⁶ This program, which likely was the first such program undertaken by a



private foundation,⁷ continued for several years and expanded to include support for Black high school students, helping them prepare for pre-med and other science-focused majors in college.

The Foundation also began providing, in 1968, grants to predominantly white medical schools around the country to identify, recruit, and prepare primarily Black but also Latinx and American Indian high school and college students for careers in the health professions. Macy also funded fellowships, beginning in 1970, to help “minority” medical school graduates obtain faculty appointments. To provide a better idea of the sheer volume of activities happening in this issue area, between 1967–1969, for example, Macy sponsored or co-sponsored 13 different meetings, convenings, and/or conferences around the country on the topic of minorities in medicine; and between 1968–1970, 26 grants were made to “support development programs to prepare more minority group students for the study of medicine.”⁸

It is important to note that, during the Bowers era, the Foundation supported Black people and other people of color not only through efforts to advance their representation in medicine, but also through efforts to improve their health status—particularly the health of poor mothers. Bowers’ programming to improve obstetrical care was discussed in Part 1 of this paper because of its focus on women, but it was spurred, in part, by perinatal mortality statistics for Black and Latina women. The 1966 Macy Annual Report notes: “Positive steps are urgently needed today to improve all aspects of medical care for all of our citizens. Although the upper third of our people receive the best, the lower third receive quite inadequate care...This country ranks fifteenth in the whole world in perinatal mortality, although we ran at the top in affluence. This is attributed at times solely to the poor maternity care received by our lower-income group, especially [Blacks] and [Latinxs].”⁹ Also cited were distressing statistics revealing the disparities in health outcomes across New York City’s many diverse communities. In response, Macy funded a variety of grants intended to improve reproductive and maternity care, including programs to improve the quality of obstetrics programs and obstetrics students in medical schools as well as grants to advance the practice of nurse-midwifery.

The Bowers era is also when the Macy Board began diversifying. As noted in Part 1, the first women had joined in 1971 and 1972, and in 1974, Dr. Harold Amos became the first Black person to join the Macy Foundation’s Board of Trustees, serving until 1990. Dr. Amos had been, in 1968, the first Black faculty member to become a department chair (in bacteriology and immunology) at Harvard Medical School—after 14 years “as the lone Black person” there. In 2003, Amos’ *New York Times* obituary noted that he wielded his considerable influence

to help advance the careers of other “minority” physicians and researchers: “He helped form the Hinton-Wright Biomedical Society, an association for minority scientists in the Boston area. He also directed a program at the Robert Wood Johnson Foundation to increase minority faculty members at medical schools. He did similar work as a trustee of the Josiah Macy Jr. Foundation, a medical education philanthropy.”¹⁰ Going forward, the Macy Board has continued to diversify in terms of race, ethnicity, and gender.

As with the changes on the board, another example—beyond straightforward conferences and grantmaking—of Macy’s commitment to advancing people of color in medicine in the 1970s was Dr. Bowers’ involvement with the launching of the Morehouse School of Medicine in Atlanta. Officially becoming a fully accredited, four-year program in the 1980s, Morehouse College’s medical school program began in 1975 as a two-year medical education program under the inaugural leadership of Dr. Louis Sullivan, who went on to serve as the Secretary of Health and Human Services under President George H. W. Bush.

In *The Morehouse Mystique*,¹¹ Sullivan and his co-author wrote: “The Josiah Macy Jr. Foundation...was also generous to the medical school over the years, in terms of money and a willingness to make introductions. John Bowers...was helpful to Sullivan...[hosting] a luncheon in New York City to introduce Sullivan to the foundation community [there]...Bowers told the [40–50] foundation leaders about the national shortage of Black physicians and noted that Morehouse...focused on minority medical education.”¹¹ According to Sullivan, Bowers introduced him to the Rockefeller and Ford foundations in New York as well as to Pew in Philadelphia and Kellogg in Michigan. “[T]he Macy Foundation has been a fundamental supporter of the school: although its grants were small (\$25,000–\$250,000), [Macy] sponsored conferences and publications for the medical school that helped offset its costs and bring it publicity. The Macy Foundation support was also crucial because it was a recognized leader in the medical education world and paved the way for others to help fund the new medical school.”

In a 2018 letter congratulating Dr. Holly Humphrey on her appointment as Macy’s newest president, Dr. Sullivan mentioned that, prior to its support in 1975 of the Morehouse Medical Education Program, Macy had also given a grant to Atlanta University for a feasibility study around the development of a new minority medical school, possibly to be housed at Atlanta University, but ultimately launched at Morehouse.¹²

In 1976, as mentioned in Part 1, the Foundation published the recommendations of its “Commission on Physicians for the Future,” which represented



the first time that the Foundation addressed the need to increase both women and people of color in medicine and the health professions more generally. However, this was not an early recognition of intersectionality as much as it was a wide-angle view of health professions manpower challenges more generally. The report called for both more women and more “minorities” in the health professions and featured separate recommendations. The recommendations for increasing people of color included the need to strengthen the curricula in secondary schools and colleges that serve large minority populations as well as the need to expand tutoring programs for people of color in medical schools. The report also called for medical schools to increase “minority” group representation on their faculties.¹³

Also in 1976, after a decade of efforts, the Macy Foundation commissioned a special report, *Minorities in Medicine: From Passivity to Positive Action 1966–76*, by former University of Washington President Charles Odegaard. In his introduction to the published report, Dr. Bowers wrote: “After a ten-year commitment to increasing minorities in medicine, [Macy] decided that it would be appropriate to invite an experienced educator to appraise developments and to forecast future needs and opportunities.”¹⁴ Dr. Odegaard spent three years researching the report and interviewed officials and students at 40 medical schools across the country.

According to news coverage of the report, the Macy Foundation urged “medical schools to enter into a new phase of recruiting Blacks, American Indians, Mexican-Americans, and Puerto Ricans to expand their numbers of future doctors.”¹⁵ This call was based on Dr. Odegaard’s finding that: “A five-fold increase in the enrollment of medical students from minority groups in the United States over the last decade has not produced enrollments matching the percentage of these minority groups in the present population.” The news report quoted Dr. Bowers as stating: “The need for such action is reflected in the ‘shocking dissimilarities’ that exist in the ratio of Black doctors to the Black population in this country.” At the time, there was one white physician for every 538 white people in the general population, but one Black physician for every 4,100 Black people in the population—with even worse ratios in some geographic regions.

The report covered a wide variety of efforts that had been and were still being pursued by medical schools to advance people of color in the health professions. These efforts—such as active recruitment of people of color; changes in admissions policies and procedures; and special support programs, including scholarships, summer academic programs, and mentoring and guidance programs—had all contributed to increasing the diversity of medical schools, but they were not then and still are not now equal to the task. The equitable representation of people of color in the health

professions is a challenge that health professions schools still grapple with today because America, after nearly 500 years, continues to struggle with the pernicious effects of genocide, slavery, legalized oppression, and structural racism.

This was acknowledged by Dr. Odegaard in the words he chose to close out his special Macy report on *Minorities in Medicine: Racist and ethnic prejudice harms each of the groups it separates, and “is not easily eradicated. Even if its direct manifestations in conscious and intentional prejudice are removed, it can survive and hurt in the actions imposed by institutional forms supported by unconscious habits. Would it help then...if efforts were made in medical schools to study, deliberately and openly, racism and ethnic prejudice as a social phenomenon within themselves? This question deserves consideration.”*¹¹

In 1978, Dr. Odegaard’s special Macy report made its way into oral arguments delivered in front of the U.S. Supreme Court, where his findings calling for more effective minority recruiting were used to argue the negative effects of racism and the need to support people of color in the educational system.⁶ The case was the Regents of University of California v. Baake (case #76-811 argued June 28, 1978) and involved a claim of “reverse discrimination” by a white man who blamed his rejection from the University of California Davis Medical School on the school’s use of racial quotas. The Regents’ argument was presented by Archibald Cox, who called the Macy report “the best reference book on this subject.”⁶ In their decision, the Supreme Court Justices upheld the concept of affirmative action, but invalidated the use of quotas.¹⁶

Finally, while many grants were awarded during the Bowers era to support academic preparation programs for students of color in science, one in particular is worth highlighting as an example. As mentioned briefly in Part 1, in 1978, a three-year, \$147,600 grant was made to Spelman College in Atlanta to help support its Summer Science Program, which provides academic preparation to entering freshmen. The program is similar to others of its kind, also supported by Macy grants, except for its focus. It is the only program based at a college for Black women. Here, without fanfare, is intersectionality—support not just for people of color in medicine or women in medicine, but for Black women in medicine, whose experiences of oppression and discrimination are unique to them. Macy recognized that “medicine is the leading career choice of students entering Spelman College” and that “...the number of Black applicants to medical school has leveled off, [but] the pool of qualified applicants at Spelman is increasing.”⁷ Without assigning too much “intersectional” significance to the grant, which was awarded for practical reasons, this does seem to be the first Macy grant that advances a broader view of increasing diversity more generally.



The 15-year period that was Dr. Bowers' presidency was, "up until that point, the most productive in [the Foundation's] history," with the "effort to increase minority representation in medicine the [Foundation's] major domestic program" with "more than \$5 million allocated for the endeavor between 1965 and 1980."⁵ According to a news story about the Macy Odegaard report, an assessment of an unnamed Macy-funded program that sought to increase people of color in medical schools found that "85% of participants graduated from medical school, and that, contrary to expectations, the majority was headed for primary care careers in internal medicine, pediatrics, and family practice. In the past, 85% would have been expected to go into surgery and obstetrics."¹⁴ The Bowers era "minorities in medicine" initiative succeeded in helping to advance diversity in medical schools and in medicine.

Hirsch and Meikle Eras

Indeed, between 1965 and 1975, the percentage of underrepresented minorities enrolled in medical schools more than tripled, from 2.4% to 8.1%, but that upward trend stalled in the late 1970s.⁵ After a close look at the situation, Macy's new president, Dr. James Hirsch, who served from 1981–1987, decided to focus the Foundation's efforts with respect to advancing people of color in medicine. Specifically, Hirsch and the Macy Board—after noticing that academic support programs for minority students had been successful, but had not been able to reach a significant number of students—decided to "redirect its major effort in the field toward the goal of enlarging the pool of qualified minority applicants—making a long-term commitment to urban and rural demonstration programs designed to provide an outstanding high school education for underrepresented minority students aspiring to careers in the health professions."⁵

The idea was that college enrichment programs were short-term, usually offering academic preparation to students on weekends and/or during the summers and that focusing programming on public high schools would allow for greater reach and more exposure. In 1982, Macy began awarding grants to local colleges and universities to upgrade public high school math and science programs in economically distressed communities of largely historically marginalized populations, such as in New York City; New Haven, Connecticut; rural Alabama; and on a Navajo reservation in Arizona. "By the end of Hirsch's presidency, in 1987, more than 2,000 high school students had enrolled in Macy-sponsored programs, meaning that around 500 students [of color] graduated each year with a more comprehensive high school education."⁵ Further, the 1987 Macy Annual Report dubbed the achievements of participating high school students "little short of amazing."¹⁷

When Dr. Thomas Meikle Jr. became Macy's president—serving from 1987–1996—he focused the Foundation on medical education reform, including efforts to improve the teaching skills of medical faculty. He also revived the Macy conference series, which had gone largely dormant. But he also recognized that Macy had a long history of commitment to supporting people of color in medicine—between 1981 and 1990, the Foundation had awarded \$13 million to help establish academic science and math programs at under-performing, largely minority high schools.⁵ By 1990, more than 4,000 high school students were participating in those programs across the country.

In 1990, an independent evaluation of the Macy high school science program recommended wide replication in more under-performing high schools after finding that the program "demonstrated that motivated students from diverse racial, economic, and geographic backgrounds could excel academically if they were challenged by a rigorous curriculum in a supportive school environment with high expectations for their performance."⁵ Dr. Meikle and the Macy board then awarded a six-year, \$4.5 million grant to establish Ventures in Education, an independent, non-profit organization charged with helping to promote replication of similar programs in high schools across the country.

According to a recent interview with Maxine Bleich, who worked at Macy for 24 years starting in the Bowers era and who left it only to run the independent Ventures in Education (VIE) organization: "Dr. Meikle's commissioned evaluation of the high school program found it to be absolutely fabulous. It was popular, topical, and disruptive. It did exactly what it was designed to do. And it kept doing it even after it became a separate entity. Ventures in Education received a large grant from the National Science Foundation during the [President Ronald] Reagan era, when government funding for things like science and education were being cut."¹⁸

By its fourth year, VIE was reaching 10,000 students in 83 disadvantaged schools, and of the 3,000 program graduates, nearly 90% were enrolled in selective four-year colleges.¹⁹ In 1996, *Academic Medicine* published an evaluation of VIE that concluded: "The findings have important implications for the AAMC's Project 3000 by 2000, showing that a rigorous academic curriculum with resources for individualized attention can facilitate the entry of minority and economically disadvantaged students into medical education, with at least 7.3% of the Ventures graduates entering medical school and nearly 70% of those applying subsequently being accepted."²⁰ Today, VIE's Maxine Bleich is retired, but an iteration of Ventures in Education lives on.



An Interwoven Thread: Historically Marginalized Populations and Today's Macy Foundation (1990s–Present)

When Dr. June Osborn became the first female Macy president in 1996, serving until 2007, she decided to focus the Foundation's grantmaking in four areas, two of which were relevant to advancing diversity in health care. They included projects to increase representation of people of color in the health care professions and projects to increase care of underserved populations.⁵

As mentioned in Part 1 of this paper, it is notable that during the Osborn era, Dr. Jordan Cohen also was serving as a member of the Macy Board. As president of AAMC, Dr. Cohen was in the process of making diversity in medicine one of his signature issues. In a 2002 *Health Affairs* article, Dr. Cohen and his co-authors argued that, aside from moral arguments about equity and fairness, there are four practical reasons to attain greater diversity in the health care workforce: 1) advancing cultural competency, 2) increasing access to high-quality health care for underserved populations, 3) strengthening and broadening the medical research agenda, and 4) ensuring optimal management of the health care system.²¹ At the time, diversity among medical school matriculants, which had been on the upswing from the early 1980s until 1996, had begun declining again.

With respect to increasing diversity among health care professionals, a representative grant made during the Osborn era was to a consortium of New York medical schools—the Associated Medical Colleges of New York—to support a post-baccalaureate program that provided remedial support to students of color who were not accepted into participating medical schools because they were considered not well-enough prepared academically.⁵ The grant program was launched by Dr. Marc Nivet, who eventually went on to work for the Macy Foundation and to serve as the chief diversity officer at AAMC. A version of the program still functions today, with funding from the New York Department of Health and participating schools.

Several other grants during the Osborn era could be considered representative of efforts to increase diversity in health care. These include the 2006 conference on women in medicine and the 2006 grant to Dr. Linda Pololi to develop and implement a culture change program in medical schools—both of which are featured in Part 1 of this paper. With the introduction of “increasing workforce diversity” as a grantmaking goal, the efforts to advance women and the efforts focused on increasing representation among people of color feel connected rather than separate from each other—both are now viewed as efforts to diversify the health professions. At this point in the archives,

it feels as if advancing diversity, at least in terms of women and people of color, had been woven into the fabric—the mission—of the Macy Foundation.

In terms of Dr. Osborn's commitment to projects to increase the care of underserved populations, a representative effort was the Macy-Morehouse Conferences on Primary Care for the Underserved. Two conferences were held at Morehouse School of Medicine—in September 1999 and September 2002—to identify ways to improve primary care, and at the same time, improve both access to and the quality of health care for the underserved.²² The range of topics addressed at the conferences, both of which were chaired by former Meharry Medical College Dean Henry Foster, included the role of primary care in improving population health, cultural competence in primary care, the effects of racism and discrimination on health, dental care for the underserved, and more. The second conference was timed to coincide with the launch at Morehouse of the new National Center for Primary Care, which was charged with tackling these topics.²²

Thibault Era

In 2008, Dr. George Thibault succeeded Dr. Osborn as Macy's president, serving until his retirement in 2018. Like Dr. Osborn, he too committed the Foundation to specific priorities, including the two most relevant to this paper: 1) improving education for the care of underserved populations, with a particular emphasis on primary care; and 2) increasing the diversity of the health professional workforce and leadership through career development for underrepresented minorities. According to Dr. Thibault, his vision was that all of Macy's funded activities would address one or more of his five total priority areas, with every grant being associated with a primary priority area while often also serving additional priorities. “This was based on the premise that no single grant or activity would bring about change,” Dr. Thibault wrote. “Change in these domains would come from the impact of a cumulative body of work.”²³

With respect to both priorities noted above, an early Thibault-era grant went, in 2009, to Dr. Fitzhugh Mullan and colleagues at The George Washington University School of Medicine and Health Sciences to rank the nation's medical schools according to their commitment to a “social mission” in medicine. According to a description of the \$750,000 grant: “There is no question that the U.S. needs more primary care providers and doctors who can meet the health care needs of underserved communities and populations. But what are medical schools doing to address these problems?”²⁴

The researchers examined the records of the nation's 141 medical schools with respect to three measures: the number of graduating physicians who practice primary care, the number of graduates who work in underserved areas, and the number of graduates who are people of color. The



researchers combined the three measures into a composite social mission score for each medical school and found wide variations among the institutions. Among the findings, which provided valuable information to medical schools and generated extensive media coverage:

- Medical schools in the Northeast generally performed poorly on all three measures and, as such, had the lowest social mission scores.
- Public medical schools graduated higher proportions of primary care physicians than their private counterparts.
- Schools with substantial National Institutes of Health research funding generally produced fewer primary care physicians and physicians practicing in underserved areas, and thus had lower social mission scores overall.
- Historically Black schools had the highest social mission scores.
- Osteopathic schools produced more primary care physicians than allopathic schools but trained fewer people of color.

As described in Part 1, also related to the two identified Thibault-era priorities above is Macy's established commitment to interprofessional education (IPE), which seeks to advance teamwork in health professions education and practice. To succeed, IPE must be built on a foundation of diversity and inclusion because it brings together health professionals from different disciplines, socioeconomic backgrounds, races, genders, ages, ethnicities, and more to create effective care teams for demographically diverse patients.

Similarly, Dr. Thibault created a new Macy Faculty Scholars program, making it into a successful signature effort. As described in Part 1, the Scholars Program awards up to \$200,000 of salary support over two years to five scholars every year as they work to implement an educational change project in their medical or nursing school. Since its inception in 2011, the program has deliberately sought diverse classes of scholars each year. While many of the 51 total scholars to date have sought to advance IPE at their institutions, others have instituted educational research projects on a wide range of relevant topics, including health equity and the social determinants of health, health disparities, implicit bias in health care, and improving care for refugee populations. According to the Macy Foundation website, one scholar, for example, "participates in the development and inclusion of an innovative curriculum on bias, diversity, health disparities, and LGBTQ topics" at NYU's medical school.

Conclusion

If we were to follow the examples set by Macy materials published in previous decades, we might be tempted to note the current numbers of Blacks, Latinxs, American Indians, and other population groups working in the health professions today. After all, we did include the current status of women in the conclusion to Part 1. But in concluding both papers, it feels important to not look at the numbers because where would we draw the line? How would we know which sub-populations to count and list as part of the general population of health care professionals? Diversity and inclusion are not about quotas or counting how many of each race, gender, sexual orientation, age group, nationality, disability, refugee status, etc. Instead, diversity is about valuing what makes every individual unique.

Not only that, but the concept of intersectionality demands that we acknowledge the fact that people are complex and can be many things at once. One person may identify as a Black woman, for example, while another describes themselves as mixed race, gender non-conforming, and neurologically atypical—among other characteristics. Whatever our individual traits, they overlap and combine, they make us us, and they cannot be isolated and treated separately.

This then is the challenge going forward: systematically ensuring that each of the health professions is committed—in both education and practice—to diversity, equity, and inclusion, with the goal of making the negative effects of harmful bias and discrimination in health care a thing of the past. The Macy Foundation is supporting innovations and advances in this effort through its 2020 strategic plan, which includes continuing support for its Faculty Scholars program and interprofessional education grants, among other things.

As former AAMC President Darrell Kirch concluded in a 2018 speech titled "The Mountaintops": "We must be relentless in surmounting the obstacles still in our path. From unconscious bias to overt harassment to gender- and race-based gaps in salary equity. We must find ways to bring more Black males, American Indians, and Alaska Natives into medicine. I think you agree that seeking equity in the health professions and equity in health care is a climb worth making."²⁵





ENDNOTES

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