WHERE HAVE ALL THE JEWISH DOCTORS GONE?

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When I graduated from Tufts University School of Medicine in 1962, nearly half of my class of about 100 students were Jewish—also, there were three women and two African-Americans. Recently, when I scanned the names of this year's graduates, I noted that only 17 of 200, about eight percent of the total, had Jewish sounding names—7 men and 10 women. Obviously that's an extremely unreliable indicator, but it suggested a trend that makes me wonder whether Jewish doctors, especially males like me, are a vanishing breed? Perhaps this change reflects the fact that more favorable social and economic dynamics are providing better career opportunities for the current generation than in the past and, if that's so, it's a good thing. Of course times have changed and women now account for more than half of entering medical students which also is a welcome development. So I asked myself, why should I care? But I do— and decided that maybe it would be useful to revisit some largely-forgotten history, specifically concerning medical school admissions.

Jews currently constitute about 2% of this country's population. During the late 19th and early 20th centuries there was a massive influx of Jewish immigrants to the United States and, once having arrived safely, many young men, as well as those who followed them, gravitated to the medical profession. After all, the field offered financial security, social acceptance, intellectual challenge and scholarly prestige and, in time, some of these factors accounted for over-representation by Jews as students and faculty at elite universities and medical schools. Between 1896 and 1900, 277 Jews graduated from American medical schools; 460 from 1901 to 1905; 716 from 1906 to 1910; 977 from 1911 to 1915 and by 1931 to 1935 the number had grown to 2,313.

To be sure, there was a long and bitter history of discrimination against Jewish doctors in Europe. In 1876, the famous Viennese surgeon Theodor Billroth published a book about the past and present state of German medical education that contained a lengthy screed against Jewish medical students: "They are untalented and stupid and will never accomplish anything…There is an entire lack of breeding at home." I wonder what Billroth would have thought about the

remarkable preponderance of Jews among Nobel Prize winners—starting with Paul Ehrlich in 1908 accounting for nearly one third of all medical Laureates. And this from a group that constitutes roughly 0.2% of the world's population.

Abraham Flexner was an obscure school principal from Louisville who was influenced by Billroth's progressive ideas about medical education and unconcerned by his anti-Semitism, although his own parents were Jewish. In 1909 Flexner was selected by the Carnegie Foundation to survey American and Canadian medical schools and personally visited 155 institutions in little more than one year. Flexner was appalled by what he found and soon followed up with a study of European medical schools. At the time, Johns Hopkins was the only medical school to require an undergraduate degree for entrance and many of the others were mere diploma mills. Abraham Flexner's iconic 399 page report recommended that only 31 medical schools be permitted to remain in business. Eventually only 81 survived and this drastically reduced the number of available places and put increased pressure on admissions committees.

In 1905 Harvard College adopted the College Entrance Examination Board as its basis for admission in an effort to attract higher caliber undergraduates. The problem was that many of the most accomplished applicants were Jewish. By 1908, the percentage of Jews in Harvard's freshman class jumped from almost zero to 7%; in 1915 it was up to 15% and by 1922 more than 22%. Mightily disturbed, President A. Lawrence Lowell implemented a new plan. Henceforth, Harvard's application form would ask detailed questions about family background and a code was devised where each prospective student was designated "j1" if "conclusively Jewish," "j2" if "a preponderance of evidence" suggested that and "j3" meant that it was "a possibility."

When Yale University named Charles Winternitz as dean of its medical school in 1920, he became one of the first Jews in the nation to hold a major academic position. The son of a poor immigrant insurance doctor, Winternitz was a Baltimore native who graduated from Johns Hopkins in 1903 and obtained his medical degree from there in 1907, working with Osler, Halstead and Welch. During his 15 year tenure at Yale, Dr. Winternitz raised the school from a second-rate institution to one of the finest in the world. However, he was irascible and sometimes brutal to subordinates and, according to Dan Oren in his book,

Joining the Club: A History of Jews and Yale, Dr. Winternitz was almost a caricature of a “self-hating” Jew striving to be accepted in polite gentile society. One former student recalled him as “one of the worst anti-Semites I ever met.” In order to achieve a “balanced” class, Winternitz devised a quota system (*numerus clausus*) and instructed the admissions committee never to admit more than five Jews and two Italian Catholics, and no blacks at all. Although at the time from fifty to sixty percent of applicants to Yale were “Hebrews”, the Dean suggested that no more than five percent should be accepted, equal to the proportion of Jews then in the general population. **(1)**

In 1931 Heywood Broun’s book, *Christians Only. A Study in Prejudice,* documented discriminatory practices especially in medical schools. He noted that in 1927, 80 per cent of non-Jewish graduates of New York’s City College and almost 50 per cent of Jewish applicants were accepted into medical school, but that three years later, non-Jewish acceptances amounted to 74 per cent while Jewish admittances had fallen to less than 20 per cent. One City College graduate, Dr. Arthur Kornberg (who won the Nobel Prize for Medicine and Physiology in 1959) recalled his own experience:

> *In the grade schools and high schools of BrooklynI was enclosed in a circle of Jewish students and friends and was unaware of any anti-Semitism directed at me. This innocence persisted until my senior year at the academically prestigious City College of New York, whose student body was then 90 percent or more Jewish. Then came the disappointment of being rejected by virtually all of the many medical schools to which I applied. But it came as no surprise. I resented then that at the College of Physicians and Surgeons of Columbia University, a close neighbor of City College, an endowed scholarship for a City College graduate went begging for nine years because there were no candidates. To this day, it rankles me.*

By the early 1930s the depression had badly hurt the medical profession. The $11,000 average annual income of physicians dropped sharply and millions of people could no longer afford to pay for medical care. After an intensive study, the Council on Medical Education of the American Medical Association concluded that there were too many doctors and issued a report advising medical schools that the training of physicians should be “drastically curtailed.” Almost thirty years earlier, in 1905, medical schools had turned out 5,600 doctors annually to serve a population of 83 million, but now the AMA

was taking the position that 4,800 doctors per year were too many for a national population of 125 million.

Not only was the AMA concerned with the domestic production of American doctors but the foreign trained as well. In 1933 its Council on Medical Education suggested that “to permit the large number of applicants who cannot be accommodated in the medical schools of the United States to study abroad and then return here to practice would inevitably lower the standards and corrupt the ideals of medicine.” More than 90 percent of those studying abroad were Jewish and this AMA observation was followed by a program designed to have state boards withdraw medical licensure opportunities from graduates of foreign universities. The immediate effect of the AMA report was to produce a sharp reduction of Jewish students in the entering classes of 1934, 1935, and 1936.

Nicholas Murray Butler, the president of Columbia University, was alarmed that an explosion of Jewish students was causing a problem. Fearing that the Anglo-Saxon establishment might withhold financial support and/or send their sons elsewhere, President Butler devised a policy of “selective admissions” in order to limit enrollment in favor of a more “natural” or “representative” constituency.” While existing examinations and preliminary requirements would be retained, eligible candidates additionally should be selected on the basis of personality and promise. During interviews applicants to the university were screened for such personal attributes as manliness, refinement, and cleanliness. Columbia’s College of Physicians and Surgeons was the first of its professional schools to adopt this policy; in 1932 it had accepted thirty-three Jewish applicants, in 1936 only twelve; in 1920 P&S had 14 percent Jewish medical students, by 1948 they were fewer than 4 percent.

Other schools followed suit, usually with Jewish quotas of 10% or lower, and only after the pattern of discriminatory admissions was firmly established, did a few medical educators attempted to justify it. One view, urged by the then secretary of the American Medical Association, himself Jewish, was that the large number of Jewish applicants was “overwhelming” American medical schools. This was especially true in northeastern states where a national survey conducted by the Conference on Jewish Relations found that most Jewish doctors practiced (in

1936, 47% in New York State, 9% in Illinois, 7% each in New Jersey and Pennsylvania, 4% in California.)

A positive result of fierce competition caused by the quota system was that only the most brilliant Jewish undergraduates succeeded and, no doubt, this natural selection process helped account for the exemplary record of Jewish physicians in academia and research. A consistent theme in many of their stories was how early in their careers opportunities were limited because of anti-Semitism in the basic sciences and in academic life. For this reason, most Jewish medical students gravitated to clinical fields where even in hard times one could always make a living. Many sought careers in allied fields, such as dentistry or pharmacy, or went abroad for medical education to Scotland or Switzerland or Germany.

After the end of World War II the situation changed drastically. Although anti-Semitism remained pervasive in many places, attitudes toward Jews shifted as Americans recoiled from the horrors of the Holocaust. As over half a million Jewish GIs returned home, many entered the higher education system. New York State, led by Governor Thomas E. Dewey, established four publicly supported nondiscriminatory medical schools which absorbed many Jewish applicants.

In June 1951, the AMA announced that it “has no desire to limit the production of properly trained physicians to serve the American people.” It expressed willingness to encourage expansion of medical training facilities and also reversed its attitude toward foreign medical schools. State licensing boards were urged that graduates of foreign schools “be accorded the same opportunities for licensure as graduates of approved medical schools in the United States.” And finally, the federal and several state governments passed nondiscrimination in higher education legislation. During the 1950s, roughly 15 percent of American physicians were Jewish, nearly 50 percent for psychiatrists, and two decades later, as a result of changing societal attitudes and both governmental and private social action the numeric quota system had effectively been phased out. Nevertheless, a survey of freshmen at American colleges found that the number of Jewish undergraduates wishing to become doctors had fallen by half, from 14 percent in 1971 to 7.1 percent in 2002.

When I graduated medical school in 1962, minority groups constituted only about one or two percent of medical students, but by 2000 the AMA reported that fully one-third were from ethnic/racial minorities: Asian-Pacific 19.4%, African-American 7.2%, all others 6.9%. Although asking about candidates' religion no longer is permitted, inquiry continues concerning race and ethnicity. Caucasians currently account for about 48% of some 20,000 medical school applicants and about half are accepted. Asians account for 20% and Hispanics or Latinos 6%, a combined acceptance rate of about 42%.

Affirmative action as it applies to higher education is a complicated subject that's far beyond this discussion. In its landmark decision in the case of Alan Bakke against the University of California (Davis) the U.S. Supreme Court invalidated the use of racial quotas and stated that the state medical school could not deny admission to a well-qualified white applicant in favor of a nonwhite candidate with lesser credentials solely on the basis of race. **(2)** Many subsequent cases further explored this subject which remains a contentious issue to this day. For example, in 2019, in a lawsuit alleging discrimination in admission against Asian Americans by Harvard University, a U.S. District Court judge ruled that Harvard's system, while imperfect, nonetheless passed constitutional muster. The case has been appealed and some legal scholars predict that the lawsuit could reach the Supreme Court.

A recent study of the gender and race or ethnic group in all U.S. medical school from 1978 through 2019 showed that the percentage of women doubled during this period, currently accounting for slightly more than half of all medical students. This change was largely due to an increase of Asian women by a factor of 12. During this same period, male matriculants fell by more than half of total enrollees, a large fall in white males offset by an increase by a factor of five of Asian men. The authors concluded that although major strides have been made in representation of women in the national medical student body, the proportions of enrollees from racial and ethnic groups that are underrepresented in medicine remain at levels well below their proportions in the national Census. The study concluded that in order to promote greater diversity, a multi-pronged effort will be required—"We cannot wait another generation for these changes to occur." **(3)**

So why do I care that far fewer Jewish students today are pursuing medical careers? After all, previous discriminatory barriers have been removed and other career opportunities exist now, especially for men. Indeed, greater diversity and gender neutrality in the medical profession should be applauded, so what's the problem? Yet, I confess that, deep down, I'm saddened and understand this seemingly positive development as a mixed blessing.

Over more than two decades, I've written four medical history books that celebrated Jewish doctors at different times and places. I'm proud of my predecessors' numerous accomplishments, often in the face of hardship and danger, but fear that absorption into both the general and medical communities came at a steep price. In one of my books, *JEWISH MEDICINE. What It Is and Why It Matters*, I argued that there is something distinct that characterized Jewish medical behavior that is not usually appreciated. Dr. Jonas Salk once remarked that although being Jewish had nothing directly to do with his success, indirectly it meant everything:

> *We are all influenced by our ancestor's tradition and heritage. For me it was not a conscious influence, but there is something in my Jewish genetic or culture lineage. Part of it may be the Jewish educational tradition. Part may be the diaspora for nomadic in spirit, we Jews seem to be constantly searching for ways to make the world a better place for all human beings… [our task] is to take the best from tradition and use it to build a world that is closer to our heart's desire.*

Bioethicist Dr. Rachel Remen perceivea a spiritual malaise within modern medicine and contends that the medical profession has lost its meaning:

> *We need something stronger than our science to hold on to, something more satisfying and sustaining…We need to help students to find meaning as skillfully as we educate them to pursue medical expertise.*

Dr. Remen understands "holiness" as a force within each of us to do good for others, to act ethically. She suggests that holiness comes from not separating our private life from our work, but merging them by infusing our professional vocations

with compassion and care. This holds not only for Jewish doctors but for all others as well. Jewish doctors are neither smarter nor more ethical than others. Moreover, I'm not concerned here with ritual, but with values and how appreciating our ethical traditions helps inform doctors' daily lives. If in the future Jewish physicians, both male and female, may be fewer in number, all the more reason to cherish our mutual legacy.

Jewish tradition teaches the importance of being part of something larger than oneself. In these difficult times, when selflessness too often is replaced by self-interest, it's especially important that physicians feel an obligation to put their patient's interests first. A value-based approach to medical practice is as much concerned with people as with disease, with relationships more than technical ability, and a fundamental Jewish mission is to to make the world a better place—in effect, to heal the world. We do present and future generations of medical students a disservice if we don't teach them how to conduct their work within a broad context that's based on their own authentic traditions—not only professional norms but religious and cultural as well. Perhaps Dr. Julius Preuss, a late 19th century German Jewish physician and historian, said it best. He asked to have inscribed on his tombstone the words *rofeih v'lo lo*—"physician and not for himself."

Throughout history, Jewish medical doctors established an admirable behavioral standard and I regret that now as they appear to be withdrawing from the stage, it comes at a time when their example is sorely needed. This not to infer that others won't do just as well, but I already miss the GPs and family docs of my youth along with countless medical scholars and researchers who have made this world a better place.

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NOTES

1. In 2010, Dr. Howard Spiro published a book that attempted to rehabilitate Winternitz's reputation. Acknowledging this "passionate humanist's", terrible temper, Spiro noted that the good manners Winternitz so admired [in others]…were swept away by his narcissism and ambition." Anxious to dispel criticism of the Dean as behaving like an anti-Semite, Dr. Spiro, himself Jewish, wrote, "It was simply the way Jews had to survive amid the largely Anglo-Saxon and Protestant New Haven population at Yale….[Winternitz] did not rise above the prejudices of his time and avoided making a public show of his Jewishness ….He never hated himself. He was too proud, too self-assured and narcissistic for that, even though he might not have chosen Jewish parents if he could have arranged matters otherwise." Winternitz's daughter Mary Cheever explained, "If he stood up for Jews and

his own Jewishness, he would not have survived at Yale. He wouldn't have been able to do the things he did." Unfortunately, Dr. Winternitz was not alone in repudiating his religious heritage. Indeed, his close friend and ally Abraham Flexner fit the very same description.

2. In 1950, when the University of California's medical school first opened, all but three of its students were Caucasian (and the three were all of Asian descent.) To help diversify its student body, the school developed two admissions pools—one exclusively for students from designated "minority" groups. In the standard admission stream for 84 slots, all candidates with a GPA below 2.5 were excluded and those remaining were ranked based on interview, GPA, MCAT scores, extracurricular activities, and letters of recommendation. The remaining 16 places were reserved for students who were disadvantaged or members of minority groups, who did not need to meet the 2.5 GPA cutoff and were not ranked against the candidates in the standard review.

Allan Bakke, a Caucasian former Marine who was in his 30s sued the medical school for discrimination when he was twice denied admission despite entrance scores significantly higher than those of other applicants accepted. Most significantly, the court upheld generally the right of schools to consider race as one factor in their admission process. They did, however, strike down UC's specific admission policy, which excluded white students from those 16 places, as unconstitutional and require it to admit the previously rejected student. Some justices thought the policy violated Fourteenth Amendment equal protection rights which guarantee all persons "the equal protection of the laws" and others argued that it was a violation of Title VI of the Civil Rights Act (1964), which bans racial discrimination by all entities receiving federal financial assistance. The basic principle of the *Bakke* decision was that, while schools cannot outright exclude anyone on the basis of race, they can use race as a "plus" factor that can be weighed in an individual's admission along with other factors like academics.

3. Less than 12% of U.S. physicians identify as either Hispanic or Black according to the Census, the percentage of these groups being 18.3% and 13.4% respectively. (Enrollees who were not U.S. citizens were not included.) During the 20 year period from 1997 through 2017, the number of U.S. medical school matriculants who were from racial and ethnic groups that are underrepresented in medicine increased by 30%. Although a modest increase in enrollment of Black women was noted (from 3.6% to 4.4% of all enrollees), the percentage of Black men decreased from 3.1% to 2.9%, their proportion in relation to the total number of all matriculants admitted to medical school during that period decreasing from 15% to 13%. A similar change occurred for Hispanic men and women and these percentages were far lower than these groups' representation in the U.S. population.