

Course: ENGL 121: Writing about Medicine and Public Health
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What One Small Primary Care Center Tells us About Healing
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Dominion Medical Associates building, located in downtown Richmond, Virginia

Scattered papers sit aimlessly on the counter next to Sheila, the receptionist. Jazz plays in the background. Magazine pages graze the tips of patients' hands as they pass the time in the waiting room. Sheila's face loosens, letting out a grin as I approach her desk. She's a small bubble of energy—chatty but pleasant, in a church girl kind of way. "How's college?" She asks before I manage to get a word out. The phone rings. Sheila lays the last few envelopes left in her hand on the counter as she reaches for the landline.

When Brenda Spain Jeffers, 77, was in an accident, Sheila was the person who answered the phone at the office. "She made me feel at home," said Brenda a retired teacher, "she made sure that I knew things would be alright."

Brenda and her family have been patients at my family's primary care practice, Dominion Medical Associates, for three generations. Brenda knows all the staff and refers to her visits as a "family affair." My father, Dr. Richard Allen Jackson, has been her doctor since he started practicing. And before him, his father, Dr. Reginald Allen Jackson, was Brenda's doctor.

When Dominion Medical opened its doors in 1911, it didn't have a name. It was a small cubical above a local pharmacy a few blocks away from its current location in downtown Richmond, Virginia. My grandfather, Dr. Isaiah Allen Jackson, started the practice with two office assistants. And it's been in my family ever since. Today, the practice has three doctors, a nurse practitioner, and 28 non-medical staff. But the purpose is the same: to provide quality healthcare for low-income and minority patients in the community.

Primary care is having an identity crisis—and not just because of the pandemic. Across the country, small facilities are closing, leading to consolidation and higher medical costs. Medical students are opting out of primary care in favor of higher-paying specialties. If top graduates are going into fields like cardiology and orthopedics, it eventually leaves practices like Dominion Medical without quality doctors. These facilities are instrumental in providing care, especially to the most vulnerable populations who can't afford to skip a primary care visit and go directly to a specialist. They are emblems of what it means to heal and to be truly healed. But in the near future, they may cease to exist.

This current crisis in health care is reviving age-old questions about medical care, in particular, who gets licensed to offer treatment and what qualifies as proper care. During the 18th century, many enslaved women brought cultural practices of their African roots into their motherhood traditions in America. As Sharla Fett describes in her book *Working Cures*, these women pursued a “vision of health that valued personal and community integration” and addressed a wider array of healing needs than those acknowledged by white physicians.¹ But these kinds of practices, that bonded patients with their caregivers, were prohibited by plantation owners whose main concern was increasing the productivity of the field workers. While owners sometimes solicited advice in secret when they noticed slaves recuperating, they publicly dismissed the expertise of African traditional medicine. Discoveries in science and the advent of new technologies pushed American medicine further away from these practices and towards more medicalized care.

The obligations of many early 1800s physicians, the first family medicine doctors, ranged from delivering births to setting fractures and treating chronic conditions.² Physicians often knew their patients well and attended to their whole family. But these physicians were, for the most part, white and treated only white patients.

That's where Black health facilities come in.

Dominion Medical is located in Richmond's Jackson Ward neighborhood. Nicknamed the “Harlem of the South,” Jackson Ward was once the mecca of Black culture. Theaters, clubs, and restaurants sprouted in the neighborhood. Well-established financial institutions attracted Black professionals. Black families moved to the area for the combination of the two.

¹ Fett, Sharla. *Working Cures: Healing, Health, and Power on Southern Slave Plantations*.

² Gutierrez, Cecilia, and Peter Scheid, “The History of Family Medicine and its Impact in US Health Care Delivery.”

Elsewhere in the country, America was opening its gates to millions of immigrants. The economy was booming. Slavery seemed like a distant past, more than a generation ago for most Americans, but its remnants were very much alive. A Black person couldn't drink from a water fountain. Public schools were segregated. The year 1911, when my great grandfather opened his clinic, marked the beginning of racial zoning laws in Richmond, dividing the city into separate blocks for white and "colored."³ Decades later, these same restrictions would lead to the neighborhood's demise.

Medical care was considered a luxury in the Black community. Hospitals were segregated. Few options existed for Black patients. And few options existed for Black doctors. My great grandfather trained in surgery and my grandfather in radiology. But no one would hire them. So they took up primary care.

Before establishing his own practice, my great grandfather helped modernize Richmond Community Hospital, the first Black patient-care facility in Virginia which opened in 1907.⁴ As my father remembers, he "started medicine one generation out of slavery because of his love for people and the limited choices for Blacks at the time."

A year before Dominion Medical was founded, a medical report would change the nature of medicine and medical education for decades to come. The 1910 Flexner Report, created by educator, Abraham Flexner, established the so-called "gold standard" for medical education. Flexner condemned the American education system, documenting a new one that flaunted a greater biomedical focus.⁵ Hidden in the report was both a race and class hierarchy. Most rural medical schools closed. And the report shuttered all but two African-American medical colleges: Howard University College of Medicine and Meharry Medical College.⁶

³ McGuireWoods Zoning and Segregation Work Group, "Zoning and Segregation in Virginia: Part 1."

⁴ Bon Secours. "Legacy Wall Honors 21 African American Richmond Community Hospital Founders."

⁵ Duffy, Thomas P. "The Flexner Report--100 years later."

⁶ Wright-Mendoza, Jessie, "The 1910 Report that Disadvantaged Minority Doctors."



Pictured from left to right are my great grandfather Dr. Isaiah Allen Jackson, my grandfather Dr. Reginald Allen Jackson, and my father Dr. Richard Allen Jackson.

My great grandfather, grandfather, and father all attended Howard for medical school. Unlike my great grandfather and grandfather, my father chose to train in internal medicine. “It fascinated me how one could handle patients with all these chronic medical problems at the same time,” he said.

Having grown up in Jackson Ward, my grandfather was well-known in the Black and white communities in Richmond and well-respected by both. Nicknamed “The Godfather,” he helped countless Black doctors establish themselves in the city.

Doctors would move to Richmond and were given office space, staff, and equipment rent-free by my grandfather, no strings attached. After a while, they would leave to establish their own practices.

Dr. Frank Royal, fresh out of medical school at Meharry and struggling to find a job in Richmond, was contacted by my grandfather about Dominion Medical. He paid for Dr. Royal’s hotel room, interviewed him, then offered him space to practice, patients, and equipment. Dr. Royal stayed for a few years before starting his own practice in the Church Hill area of downtown Richmond.

Dr. Frank Royal went on to become the chairman and president of the National Medical Association, chief of staff of the Richmond Community Hospital, a member on the board directors of SunTrust Banks and Smithfield Foods, and a director of Hospital Corporation of America before his retirement.

Like the doctors he welcomed, my grandfather treated his patients like family. Brenda never thought about going to another primary care facility because “the Jacksons were physicians [my

family] could trust.” She has faith in the doctors. And believes the sense of community is unmatched. “If you are sick you are never sick alone. If you are feeling bad you are never feeling bad alone,” said Brenda. Her hypertension, among other chronic conditions, required being in close contact with doctors — with healers she trusted.

Ever since Brenda’s hypertension walked into her life, it’s forced her to think twice about what she eats, to exercise more often, and to remember to take daily medications. But focusing only on Brenda’s illness misses out on the root of the problem. Hypertension is a chronic disease that requires making important lifestyle changes. But more importantly, good hypertension management requires a quality healthcare team to support you through these changes. Management goes “beyond telling patients to restrict salt and alcohol intake,” said my father. “You have to monitor a range of things such as electrolytes along with other side effects as a result of the medication.”

Hypertension, the medical name for high blood pressure, arises when blood pushes too hard against the walls of the arteries. While the causes are unknown, many experts point to the kidney as the main culprit. Damaged kidneys struggle to filter out blood, regulate blood pressure and flush out toxins. When kidneys can’t do their job, salt and toxins build up, skyrocketing pressure. But the long-term implications extend beyond the kidneys to heart disease, heart attack, and stroke.

These chronic illnesses can wreak havoc on your body years before you develop symptoms. Healthy arteries are flexible and strong, allowing blood cells to flow freely through them. High blood pressure stiffens the arteries, disrupting the flow of blood cells and causing traffic jams.

At Dominion Medical, hypertension is widely prevalent among its patients who are largely low-income, Black, and on Medicaid. But the doctors go above and beyond to ensure their patients and their conditions are cared for.

In the 1960s, my grandfather would drive thirty minutes to visit a homebound patient who lived on a farm. The family couldn’t afford the doctor’s visits. But they raised cows and would pay him with a large cardboard box filled with eight to ten steaks. My grandfather also made house calls to Brenda’s family and attended both her parent’s funerals.

“Your daddy and granddaddy are like brothers to me,” said Brenda.

My grandfather saw his role as a physician and as a community healer—and not just when his patients were sick. Most years, my grandfather rented a large boat and hosted fishing trips for his patients and staff. On many occasions, when a patient got old and was about to lose their house, he would buy the home so they could live there rent-free for the rest of their lives.

In the 1980s, the office hosted a ball for all the elderly patients (anyone over 65). It was

upstairs at Hotel John Marshall, a historic hotel in downtown Richmond. Shrimp cocktails, sliced beef roast, and roasted salmon were served along with a selection of desserts. Brenda remembers dropping her mother off. Her father had since died. Her mother, like most of the women, wore a long, formal gown. The patients danced the night away, meeting other seniors and staff throughout the night. “You don’t find a lot of doctors doing stuff like that with their patients,” said Brenda.

The community formed naturally because most staff lived, worked, and shopped in the area, including my grandfather. He wore a grey, polyester suit and tie everywhere he went — around the house, attending sporting events, grocery shopping you name it. Every holiday, he stopped by Slaughter’s restaurant on 2nd street, a local hangout that served the best fried chitterlings in town. Despite his buttoned-up look, he could always be found cracking a joke.

My grandfather and his family lived next to Maggie Walker, the first African-American woman to charter and serve as the president of a bank. After moving to another house, he donated his home to the governor to establish The Maggie L. Walker National Historic museum in her honor which was designated a U.S. National Historic Landmark in 1975.

When Jackson Ward started to dwindle, many businesses moved away from the community. Even after the clinic expanded in 1985, my grandfather and father were determined to keep it in Jackson Ward. When Brenda was younger and more agile, she walked to the office which is located around the corner from her church.

Brenda is active in her church community and leads the senior ministry. Medical organizations often speak with her group about JenCare, a competing senior medical center dedicated to providing primary and specialty care services for Medicare-eligible seniors. The company picks up patients and drives them to see different doctors, making it a convenient option for many seniors. “They may be good but I just don’t have a good feeling about JenCare,” said Brenda. Convenience isn’t enough. She needs to make sure the doctors listen to her. And that she can trust them. Something harder to gauge from a larger, more confusing organization like JenCare. Facilities like JenCare represent the future of medicine—more efficient, corporate-run healthcare centers that are chipping away at independently run primary care clinics.

While they may provide a range of services, they do not offer the same kind of primary care that patients in Richmond—and so many other places—have grown up with. And yet, the growth of these kinds of big medicine is tarnishing the allure of primary care. In fact, America’s three main primary care fields—family, internal medicine, and pediatrics—are all understaffed. In 2010, there was roughly 1 doctor for every 1,500 people.⁷ And this number is only getting worse. By 2032, there will be a shortage of as many as 50,000 primary care physicians according to some estimates.⁸

⁷ National Center for Health Statistics. *Health, United States, 2010: With Special Feature on Death and Dying*.

⁸ IHS Markit Ltd., “The Complexities of Physician Supply and Demand: Projections from 2018 to 2033.”

To make it worse, for communities like Jackson Ward, only about 3% of the country's doctors identify as Black, well below their overall proportion of the population.⁹ One study estimated that if the Flexner report had not shuttered five main Black medical hospitals, there would be upwards of 30,000 more Black physicians in the workforce.¹⁰

Experts have grappled with medical care for centuries and have come up short. As Harriet Washington explains in her book, *Medical Apartheid*, a “racial health divide confronts us everywhere we look, from doubled black infant death rates to African American life expectancies that fall years behind whites’.” America lags behind most developed nations in healthcare quality even though we spend the most money per gross domestic product on healthcare.¹¹ The nation's health statistics are appalling: America is the only developed country with an increasing maternal mortality rate,¹² has an obesity rate two times higher than the average for other developed countries,¹³ and has the highest number of avoidable deaths.¹⁴ People are lured into specialties over primary care. Medical discovery is emphasized over prevention. Health insurance choice is emphasized over access. These economic forces have changed what it means to be cared for, and what it means to get treatment.

Primary care physicians are meant to be the coordinators of individuals' health, but policymakers have lost focus on their founding purpose and left communities behind because of it.

Historically Black hospitals and facilities were once the primary healthcare option for the Black community. But what role do they play in today's age? These hospitals are scratching their heads. In 1992, there were 7 historically Black hospitals remaining. Among them was Richmond Community Hospital where my great grandfather started his career. These hospitals serve primarily poor and underinsured communities. Today, all but three, Howard University Hospital, Richmond Community Hospital, and Southeast Specialty Hospital, have closed their doors. And these remaining hospitals barely have a pulse. Bon Secours Virginia Health System acquired Richmond Community Hospital in 1995. But the other two lost over a million dollars each last year.

The patient-centered model of Black hospitals will outlive their slow death. Policymakers, technology companies, and health practitioners are brainstorming creative ways to reorient the healthcare system towards a more patient, or value-based system. CityBlock Health, a

⁹ Alltucker, Ken, “U.S. doctor shortage worsens as efforts to recruit Black and Latino students stall.”

¹⁰ Campbell KM, Corral I, Infante Linares JL, Tumin D. Projected Estimates of African American Medical Graduates of Closed Historically Black Medical Schools.

¹¹ Cox, Cynthia, Rabah Kamal, and Giorlando Ramirez, “How does health spending in the U.S. compare to other countries?”

¹² Melillo, Gianna, “US Ranks Worst in Maternal Care, Mortality Compared with 10 Other Developed Nations.”

¹³ Roosa Tikkanen and Melinda K. Abrams, *U.S. Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?* (Commonwealth Fund, Jan. 2020). <https://doi.org/10.26099/7avy-fc29>

¹⁴ Ibid.

technology company based in Brooklyn, NY, follows the philosophy that “health is local.” It provides primary care, substance use disorder treatment, and behavioral health services along with access to transportation, housing, and food for underserved communities. The company also hires community health partners to go into communities, identify, and address the barriers to and social influences on good health. The company employs people to do the work that was built into the philosophy of many Black health facilities.

What Cityblock and other health practitioners are attempting to build is trust, a trait doctors are rarely taught in medical school, but is critical for providing quality care, particularly for low-income communities. “I think trust is a big factor in treatment in these low-income communities because they are used to being treated as second-class citizens,” said my father. “Patients are often very weary or paranoid about the medical profession. Especially because of things like the [Tuskegee Study](#). When you are from the Black community and you work with low-income groups, they are more likely to follow your suggestions.” Everything the office has done for Brenda and her family makes her know she can trust the facility.

There is something more profound than the facility closings and the shrinking trust, that frightens me: medicine has adopted a closed-minded vision of what it means to restore health. It has marched without misstep towards a more rigorous science, a vision the Flexner report, medical schools, and other bodies have often backed. I believe in the power of science and the elegance of medical discovery. But medicine is imperfect. And in its enthused, bewildered walk towards advancement—towards clarity—it hasn’t looked back at the communities it’s stomped on along the way.

What if we reevaluate our perception of healing and the systems, laws, and beliefs that have grounded it? What if we admit to the health systems’ failures and the wounds, the cuts, and the trauma they have produced? What if we reassess the people we pedestal as healers? And in doing so we acknowledge the healers we’ve forgotten, the facilities we’ve shuttered, and the communities we’ve left behind

I don’t recognize the new Jackson Ward. The infrastructure of the neighborhood has largely changed. Many homes were converted into condominiums after the tsunami of urbanization. The vibrant entertainment and financial neighborhood has disappeared. But the same bushy trees still line the 3rd street sidewalk by the office. Their tiny pink flowers still show themselves around Easter time. The office still serves majority patients of color, but there are more Hispanic folks these days. The generations of fishing trips and dances are long gone, but that doesn’t mean there aren’t other ways to provide trust. “Medicine is really about loving people and caring about their health and about their lives,” said my father. “That’s the most important part about building trust.”

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