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Discriminatory Patterns In Community Health Services

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*DISCRIMINATORY PATTERNS IN COMMUNITY HEALTH SERVICES**

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Washington

Discriminations against minorities constitute a barrier to the availability of adequate medical care to all Americans as real and more deeply significant than economic factors and inadequacies in health personnel and facilities. Although the complexity of the problems of meeting the costs of illness and of providing sufficient personnel and equipment for treatment and prevention has given rise to sharp controversy as to how the needs should be met, this failure of concurrence is harmony compared to the violent subjective disturbances aroused by the simple propositions that one sick person deserves as good care as another and that nature of illness should be the sole criterion for treatment to be rendered. It is this emotional hostility of one human being toward another, conditioned for the most part in the earlier years of life, which must be alleviated, if health deterrents due to discriminations are to be eradicated.

We are described as a Christian nation, but the parable of the Samaritan has no meaning in regions where the critically injured may be turned away to die, because hospitals in those areas do not admit patients of their skin color. The noble ethics of Hippocrates carry little weight with physicians who deny colleagues who differ from them more or less in descent or religion, the benefits of professional affiliation for professional improvement with concurrent increase in service potential. Who can assay the personality damage to segregator and segregated resulting from jim-crow wards, consultations by sufferance, patronizing helping hands and various exclusion practices? Nor can one estimate the loss of life, prolongation and aggravation of illness, and economic privation which stem from these causes.

Discriminative practice in health facilities victimizes more than one group, and is not confined to any particular region. Negro, Mexican, Filipino, Japanese, Chinese, Italian and Jew, all know the effects of these practices. The Negro is the largest group discriminated against and it is in respect to him that the patterns have their fullest and most extreme expression.

South, North, East and West, city and country, all have their discrim-

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inatory practices, sometimes frankly and sometimes subtly executed. Discrimination is at its worst in the South where the bulk of the Negro population is located. Today in Chicago, the home of the American Medical Association, and the seat of one of the nation's great universities, a Negro, Mexican, Filipino or Japanese cannot be admitted to a large majority of the city's voluntary hospitals, and this university was picketed last December in protest against the discriminatory bars of its hospital and its failure in recent years to admit any Negro students to its medical school.

In many places, in the South particularly, there are no hospital facilities whatever available to Negroes. In tax-supported hospitals, Negro patients are generally accommodated. This admission is regularly on segregated wards or to separate institutions in the South and not infrequently elsewhere.

The quality of the segregated accommodations is usually inferior. Sometimes it has ludicrous aspects as in the Gallinger Municipal Hospital here in Washington, where on a given service the ward at one end of a corridor will be used for white and that at the other for colored patients. In cases of overflow, the speaker has seen beds rolled into the aisles of the colored ward rather than install colored patients in empty beds in the adjacent ward assigned to whites. In Cook County Hospital, Chicago, Negroes constitute a majority of the patients who pay to enter, a curious reflection of the unavailability to them of hospitalization elsewhere.

Voluntary hospitals on a country-wide basis are the greatest offenders as to exclusion practices. Even the Federal veterans' hospitals are guilty, for of 127 such hospitals operating as of November 3, 1947, 24 had separate wards for Negro veterans and 19 of the hospitals, all located in the South, did not admit Negroes at all except in cases of medical emergency.

Discriminatory practices against the Negro physician are even more severe. South of the Mason-Dixon line he is excluded from membership in the official county and state medical societies recognized by the American Medical Association, and hence from staff appointments to most approved hospitals. Such appointments are only beginning to become available in other sections where he *can* join the county society and the A. M. A. This means loss of opportunity for professional improvement and surrender of his patients at the hospital door.

With the advent of the various types of prepayment medical care plans, the Negro has again found difficulty in being included in such plans. Often he is excluded altogether. Sometimes he may be admitted to a plan, but as in a certain major city, where Negroes may join Blue Cross, the only facility available is a decidedly inferior separate hospital.

These conditions have long been well known and are for the most part adequately documented for corrective action. Some localities have been surveyed repeatedly, always with the same acknowledged result, that discriminatory practices have been found and that the minority group suffers considerably therefrom. In some communities the

findings in this specific area of surveys by most eminent authorities will receive no action for years. There is practically never a denial that conditions are bad and need correction. Usually a community willingness toward corrective efforts through separate segregated facilities will be encountered, but there will be a deaf resistance to abandonment of segregative policy.

The futility of "separate but equal" arrangements as solutions of the problem has been well demonstrated. Appraising bodies of the greatest prestige and integrity have urged the abolition of discrimination and segregation in our national life, as a whole and in hospitals particularly, in the reports of the President's Committee on Civil Rights, the President's Commission on Higher Education, and of the Commission on Hospital Care. Where integration both of patient and physician has been sincerely tried it has proved uniformly successful.

Here and there about the land and in some major organizations the absurdity of prevalent discriminatory patterns has been recognized and major steps toward their elimination taken, in respect to the admission of patients to hospitals, of physicians to staffs, and of citizens to medical care plans.

In all of this progressive activity the powerful potential for constructive action of the American Medical Association has been conspicuous by its absence. No body could be more aware of the facts or conscious that its leadership would have great educative value in realigning the policies of the countless city councils, chambers of commerce, boards of trade and hospital boards throughout the country, which now determine and control the way in which health facilities are made available to the people.

It is hoped that the studies of this Conference will lead to recommendations to the President for removal from the national picture of discriminatory patterns in health care in all their devious ramifications.

N.B. Fuller treatment of this subject, including discrimination in professional education, may be found in two papers by the writer, "Medical Care and the Plight of the Negro", National Association for Advancement of Colored People, 20 *N. 40th Street, New York* 18, *New York,* 38 *pp.,* 1947, *and "Progress and Portents for the Negro in Medicine", The Crisis, v.* 55, *pp.* 107-122, 125-126, *April,* 1948.