file Mayor's Commission

A Statement
Presented Before the
Committee
To Study Racial Problems in Hospital Practice
of the
Chicago Medical Society
and the
Institute of Medicine

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Chicago Commission on Human Relations
54 West Hubbard Street
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I am deeply appreciative of this opportunity to meet with you, for certainly, yours is an extremely important task. Your decisions and recommendations hold potent for not only the medical profession and the hospital community, but thousands of Chicago's citizens as well.

If I may, I would first like to give you some brief background concerning the Chicago Commission on Human Relations and its interest in your work. The Commission is an official agency of the City government, established by ordinance to advise the Mayor and City departments on human relations problems and to mobilize community support for good human relations throughout our city.

In the field of health, the Commission and its staff have been increasingly active in the last few years. For, as Chicago has experienced increased population changes and movements, the Commission has received more and more complaints from individuals who feel that they have been denied hospitalization, or treatment by doctors, or staff appointments, or hospital employment because of their minority group status. As we have received these complaints, our job has been to counsel, negotiate, ameliorate and investigate under the law. However, in the case of some complaints, we have been unable to affect a satisfactory resolution. Therefore, late in 1957, the Commission's Advisory Committee on Health requested that the Chairman and the Executive Director of the Commission meet with Dr. Hirsch, President of the Chicago Medical Society, for the following purposes -

1. To determine the Society's position regarding discriminatory practices relating to the admission of patients, segregation of patients, staff appointments for nonwhite physicians, and treatment of nonwhite patients in white physician's offices.

2. To seek action by the Society that would reduce, throughout our community, the prevalence of this discriminatory treatment.

3. To establish with the Society a relationship which would enable the Commission to refer to the Society for redress, those justified complaints of discriminatory treatment that cannot be satisfactorily negotiated, or referred for legal action because the discriminatory act is not defined as illegal in state or municipal codes.

When the Commission's representatives met with Dr. Hirsch to discuss these matters, they were pleased to find that he recognized that the Society has some responsibility in these areas of concern. And shortly after this meeting, Dr. Hirsch informed the Commission that a joint Medical Society-Institute of Medicine Committee was being established to survey the racial aspects of hospital practices.

It is because of the preceding developments, therefore, that we feel your deliberations are of particular interest to the Commission. We hope that we may be of service to you today, and in the future, and that you will keep us informed of your proceedings.

I am here today representing the Commission, at Dr. Hirsch's request. He asked me if I would make a statement concerning the racial aspects of patient medical care, or, in other words to try to define the problems of the minority group consumers who seek medical care in Chicago. I will attempt to limit my comments to this facet of the total problem. However, there may be some who question either that there are any real racial problems in the total area of hospital care, or those who wonder about the extent and seriousness of these problems. Although I will not belabor the point, we will be happy to provide copies of reports by the Institute of Medicine, the Metropolitan Welfare Council, and the U. S. Public Health Service, each providing basic data that demonstrates the serious limitations placed upon nonwhite Chicagoans who seek equal opportunities in the medical-hospital field.

Limiting ourselves today, however, to a discussion of nonwhite patients seeking hospital care, I would list three basic areas where problems related to race are too often encountered - first, admission to a hospital; second, room assignment when admitted; and third, the opportunity to secure the benefits of pre-paid voluntary health insurance.

Let me expand on each of these points.

First, problems of admission to hospitals. Since Chicago has an

anti-discriminatory hospital ordinance that makes it illegal to deny admission on the basis of race or religion, it is extremely difficult to determine the extent of such discrimination. However, the Commission has part of the responsibility for the administration of this ordinance and our investigations of complaints received under this law lead us to believe that devices to keep nonwhite patients from being admitted to predominantly white hospitals are not uncommon. We substantiate this view on the basis of information received from doctors on hospital staffs, hospital employees, patients and even hospital administrators who often speak frankly of discriminatory admissions policies in other hospitals in their neighborhood. I am sure that, should you wish to seek further substantiation of this point, you could find several hospital administrators who would, in confidence, be willing to describe the basic patterns of discrimination in admissions. I think also that you could find white physicians who are members of your Society who could tell you of discriminatory treatment against themselves because they admitted some or what was described as "too many" nonwhite patients to particular hospitals.

I am sure, however, that you are fully aware that any analysis of discrimination against patients seeking admission to a hospital must basically point to the fact that it is usually through the staff doctor that discrimination or the failure to serve is carried out.

Most patients enter hospitals, not by knocking on the front door for admission, but by seeking admission through a doctor on the hospital's staff. It is therefore at the medical staff level that the Commission feels the basic problem exists in admission of patients on a non-discriminatory basis. I am sure that your coming meetings will include an investigation of the effect of a hospital's all-white medical staff upon the racial character of patients admitted to that hospital. I think that we must face the fact that the basic discrimination against nonwhite patients seeking hospitalization is not usually individual, but is a broad pattern that exists because the great majority of Chicago's hospitals have all white medical

staff members who admit all or mostly white patients. In many of these hospitals, the only Negro patients are a few who enter through the emergency room. Incidentally, it is in the emergency room that most hospitals must make some decision concerning equality of service and it is because of discriminatory treatment in emergency rooms that we receive most of our complaints of discrimination.

I do not want to belabor you with statistics, but I believe that the data on places of births by race demonstrates the pattern of private hospital service to nonwhites. This data also demonstrates that a hospital can, if it wishes, remain segregated or all white through its geographical location or by maintaining an all-white staff whose members do not treat or have Negro patients. For example, in 1956-

1/4th of Chicago's births were Negro babies

88% of these births occurred in 3 governmental hospitals. The other 12% of the Negro births occurred in the 49 private hospitals with maternity sections

these 49 private hospitals with maternity sections delivered 8% less of the Negro hospital births than they did in 1953.

By the way, if as I present this paper, you have any questions concerning the sources of my information, I will be very happy to provide copies of the sources upon your request.

Passing now to the second point, the problem of room assignment on a non-segregated basis. About a year and a half ago we interviewed 56 of the administrators of Chicago's private hospitals. Although none admitted directly to discrimination in admission, they pointed their finger to staff doctors and placed the burden upon them. When asked about patient segregation, over half said that patients in their hospitals were segregated in some manner. This admission is interesting to note because the anti-discriminatory hospital ordinance defines segregation of patients as illegal. Nonetheless, the administrators described various devices to maintain segregation, each involving the staff physician's cooperation. The physicians, when calling in to reserve a room, sometimes used a number code to indicate race of their patients. Hospital records were kept with devices such as stars, checks or asterisks to designate race of

the patients in various rooms or entire floors, or sections of the hospital were designated as "colored."

Perhaps the nation's moral climate since the Supreme Court decided against the "separate but equal" concept of education has been the cause of an increasing number of cases filed with us complaining of "separate but equal" facilities in hospitals. Only last month our investigation of one complaint substantiated the patient's charge of segregation and the hospital, the corporation counsel and the complainant settled out of court. Can you imagine, however, the injury to the hospital as well as the medical profession should the next such case be publicly tried?

Administrators patently justify patient segregation on the grounds that some of their staff doctors or some of their white patients demand it. If this should be true, they risk court prosecution, and maintain an economically, medically and morally unjustifiable practice to placate the whims of a few.

Separate but equal medical treatment is no more justifiable than separate but equal educational facilities. And yet, it is probable that many of us who cluck our tongues about the school segregation situation in Little Rock don't bat an eyelash about the segregation of the sick people in Chicago.

Before leaving this point, I would like to suggest that you might wish to hear from Dietrich Reitzes who recently completed a nationwide study for the Rockefeller Foundation entitled Negroes in Medicine. In this study, Reitzes points out that hospital officials are in a position where they often define the setting for the hospital's patients; they are generally accepted as authority. And in most areas of life where there is an authority, we in human relations find that the firm and yet understanding hand will result in confidence rather than complaints. Certainly you doctors can understand this. Reitzes notes that where hospital officials and staff doctors support unsegregated facilities, people accept the situation about as readily as they accept working in unsegregated offices, staying in unsegregated hotels or going to unsegregated movies. To further substantiate

this point. I would suggest that you might like to hear also from Brother Dominic, Administrator of Alexian Brothers, about the experiences at his hospital when a desegregation policy was established.

The third point was that increasing numbers of nonwhite patients find that a very real problem is their inability to use their voluntary pre-paid health insurance. I think that you will readily understand the frustration of many of Chicago's nonwhite citizens who receive a portion of their income in the form of hospital insurance.that is too often of no use to them because they can't get into private hospitals.

And where can they turn for redress?

Turn to Blue Cross? Blue Cross says it insures but doesn't guarantee treatment.

Turn to the hospitals? They say we don't discriminate. Our doctors determine who our patients are.

Turn to white doctors? They can refuse to serve a person, excepting in an emergency, because of his race.

Turn to the Negro doctor? They are often limited to the staff of one 200-bed hospital and are unable to hospitalize nearly as many patients as they need to.

So where can the nonwhite patient turn? Obviously, to Cook County. But he didn't agree to accept part of his income in hospital insurance so that he could go to a public hospital.

I think that you can see what is too often the ultimate and inevitable reaction. The first is that Blue Cross is valuless - drop it. The second is, if a voluntary plan won't work, then perhaps a compulsory plan will. Certainly you should seek evidence from others, particularly in labor, who can verify our feeling that there is a storm gathering around the concept of voluntary pre-paid health insurance plans. For our City's nonwhite citizens, 1/6th of the total population, do not want insurance that doesn't really insure.

This analysis of the nonwhite consumer's three basic problems has been necessarily cursory because of the limited time. I have overlooked many factors, I realize, but I hope that I have indicated some additional resource persons who can give expanded testimony on several of these points.

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As a layman, I think I represent most laymen in their respect for the tremendous advances and services that our free form of private medicine has provided us. Sometimes I wonder of there has been any technical progress half as important to humanity as that provided by medical science. The lifesaving, hope-giving advances in medicine and the spirit of the Hypocratic Oath make all of us feel deep respect for your profession. And certainly, the basic essentials of free medicine - the right to private practice, the patient's free choice of a physician and the voluntary forms of pre-paid health insurance have contributed greatly to the medical advantages that we now enjoy.

But it seems to me that some of these essentials of free medicine are threatened today because of a vacuum of responsibility for the racial inequities that have been too long associated with free medicine in Chicago. I stress this idea of a vacuum of responsibility because I know, as a person working daily with health and human relations problems, that our main difficulty in solving these problems is not that medical and hospital people won't admit that they exist, but rather, that no one will admit that they are responsible. And therein lies the threat to the free traditions of the medical and hospital professions. For, when the physicians and their professional organizations, the hospital administrators and their professional organizations, the hospital boards and the hospital insurance plans each deny responsibility, or say that someone else in the group has it, growing problems remain unsolved. As a result, public pressure grows - pressure for public action, pressure for action by groups outside the field of medicine. Let me cite a few examples from my vantage point as a public official.

In the last three years we have seen three different laws passed in Chicago and Illinois, each defining as illegal various discriminatory practices in the field of health. And there is growing community pressure for more laws to legally combat discrimination in medicine. These laws, and the clamor for more, are a result, not of inherent community interest in passing laws, but rather, an attempt to give government responsibility for mandatory action in insuring equality because medicine has not taken the responsibility for voluntary action. I would suggest that you might wish to hear Alderman Leon Despres speak to you on this issue.

Financial contributions are now responding to public and community concerns. Last month, Illinois Bell Telephone announced a policy stating that, in the future, hospitals requesting contributions will be asked whether their admissions policy is restricted as to race, creed or color. Last week we received a letter from the president of a large industrial firm in which he includes a list of hospitals to which the firm has traditionally contributed. The president asks in his letter, "which of these hospitals carry out a policy of non-discriminatory patient intake," and notes that his firm which has many nonwhite employees no longer plans to contribute to hospitals that will not serve those employees. Soon, we have also been informed, a large retailing firm plans to announce a policy similar to that of the Illinois Bell Telephone Company.

We hear of increasing demands for publicity as a means of forcing responsibility for discriminatory practices upon medical and hospital professionals. We have heard of individuals who are considering test cases before the Illinois courts. There are efforts to place nondiscriminatory riders on the Hill-Burton Act. And, in our city, one cannot help but be impressed with the growing disillusion with the Blue Cross-Blue Shield Plan among nonwhite citizens.

All of these public pressures, I mention because I see them as a public response to the vacuum of responsibility and voluntary action that has been too evident in the medical community.

The Commission is heartened, however, by the fact that the Medical Society has established this committee. There is precedent in other northern cities for such a body, New York being one example. Should you hear from Reitzes concerning his study, I am sure that he will be able to demonstrate to you that the medical profession in Chicago has its biggest problem in overcoming its own fears rather than in taking the steps necessary to solve the problem. Medical Societies in other northern cities have already taken meaningful and effective action. The result has been a profession strengthened by community respect and inwardly fortified by the spirit of ethical action.

If you will but advise the members of your Medical Society to take responsibility and action where it is honestly theirs, you will have served your profession well, strengthened the bulwalks of free medicine in Chicago, and made our city a better place for all of us to live.