

# Legacy of racial segregation endures at many U.S. hospitals

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In the early 1940s, Bernard Lown, MD, was temporarily expelled from Johns Hopkins School of Medicine after it was discovered that, in an act of protest, he had purposely altered blood-bottle labels that indicated the race of the blood donor from whom it was drawn.

After a threatened protest, Dr. Lown—the inventor of the defibrillator—was reinstated but removed from his job at the blood bank, which continued to segregate its supply according to the race of the donor.

Some 80 years after Dr. Lown’s encounter with that baseless form of medical racism, the organization that bears his name—the Lown Institute—has released data showing that many of the nation’s urban hospital markets are highly segregated.

Lown Institute researchers ranked 3,200 hospitals on inclusivity after assessing how well the demographics of a hospital’s Medicare patients (using 2018 claims data) matched the hospitals’ surrounding community.

“The difference between the most and least inclusive hospitals is stark, especially when they are blocks away from each other,” said Vikas Saini, MD, president of the Lown Institute.

Key takeaways from the report include:

- Many major cities have a high proportion at the top and bottom of the inclusivity rankings.
- In the top 50 most inclusive hospitals, people of color made up 61% of patients on average, compared with 17% in the 50 least inclusive hospitals.
- Many elite hospitals ranked poorly on racial inclusivity. Of the 20 hospitals on the *U.S. News & World Report* “honor roll,” 11 were in the bottom third for inclusivity and only five were in the top third.

Dr. Saini hosted an online program discussing the findings with a virtual panel that included medical ethicist Harriet Washington, who explained why hospitals in close proximity can be on opposite ends

of the inclusivity scale.

“The operative verb here is ‘choose,’ who’s choosing, and what are their choices?” said Washington, author of the book *Medical Apartheid*. Black, Hispanic and other underserved populations often face a constricted set of choices and lack a primary care physician to serve as their advocate, she added.

Decisions can be based on economic or social factors or on past experiences.

“Who would choose to go to an institution where they know their chances of being rejected as drug-seeking are extremely high?” Washington asked. “Who would choose to go to an institution where they know the maternal death rate is higher than that in some developing countries?”

AMA Chief Health Equity Officer Aletha Maybank, MD, MPH, was also a panelist, and she talked about the AMA’s “Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity: 2021–2023.”

Just as the Lown Institute has measured inclusivity, Dr. Maybank noted that there are metrics being used to transparently assess progress implementing the AMA’s plan to advance equity.

Metrics are useful in holding people accountable, she said, but they should do more than just point fingers.

“As folks get ranked and hospitals get ranked, I think it’s important to also provide some sense of hope that you can do better,” she said. “You can learn more, and you can show up differently for the people that you are serving.”

Read about why inequity should be treated as an unwanted variation in care.

## Improvement needs committed leaders

Such changes cannot come about without committed leadership, said Dr. Maybank, who credited the effort put forth by AMA Executive Vice President and CEO James L. Madara, MD, to help the AMA equity plan come to fruition.

Learn more from Dr. Madara about how the AMA’s trusted voice is being marshaled to advance health equity.

## Road to reconciliation

In addition to its strategic plan, Dr. Maybank noted that the AMA adopted policy declaring racism a public health threat and issued an apology to the National Medical Association for the AMA's role in creating and perpetuating segregation and discrimination in health care.

In the apology, the AMA noted “the importance of reconciliation, truth-telling and righting the wrongs of the past,” Dr. Maybank said.

Among those wrongs is supporting the recommendations of the 1910 *Flexner Report* that led to closing five of the seven Black medical schools that existed at the time. That hampered the ability for Black people to become physicians and limited access to care in African American communities, “which has impact to this day,” Dr. Maybank said, as the Lown Institute report's findings clearly show.

Dive deeper into the Lown Institute data on U.S. hospitals' racial inclusivity.