RESOLUTION

Subject: Actualizing Health Equity through Patient Care, Research, and Medical Education

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Referred to: Reference Committee

WHEREAS, systemic racism and structural racism are synonymous and are generally defined as ways of maintaining racism at the population level socially, economically, politically, and legally[1]; and

WHEREAS, institutional racism is a form of structural racism that exists in institutions such as universities or health systems as policies and practices that discriminate against people based on race/ethnicity and give advantages to non-minorities, interpersonal racism occurs between individuals, and internalized racism occurs within the individual[1]; and

WHEREAS, one example of structural racism is residential racial segregation, which has led to reduced health outcomes influenced by environmental and city zoning issues such as the following: increased air pollution corresponding to asthma, lead toxicity corresponding to developmental delays, and limited access to healthy food corresponding to increasing non-communicable diseases such as diabetes, obesity, and hypertension[2]; and

WHEREAS, continued discussion on these issues is needed in organized medicine to further understanding and efforts towards diversity, inclusion, anti-racism, health equity, and learning[1,2]; and

WHEREAS, socioeconomic factors, such as income, education, race, ethnicity, and geographic location (i.e. social determinants of health) play a significant role in determining health outcomes[3-6]; and

WHEREAS, diversity in students and their learning environments has been shown to have higher learning outcomes as well as a self-perceived educational enhancement[7-9];

WHEREAS, a lack of diversity and inclusion in medical education materials and staff hinders medical student preparedness towards treating heterogeneous populations[10-14]; and

WHEREAS, diversity in physicians increases access to healthcare for minorities and the underserved as well as minority and underserved patient satisfaction and compliance[9,15]; and

WHEREAS, diversity in business increases profits, and while there is less research related to healthcare administration, there are positive associations between diversity, patient outcomes, quality care metrics, and financial performance[16,17]; and

WHEREAS, while diversity in the healthcare field is increasing, there is still progress to be made, as minority groups continue to be heavily underrepresented as medical students, physicians, and in healthcare leadership[18-21]; and

WHEREAS, to create and implement innovative solutions, more analyses on gaps in diversity, inclusion, and anti-racism in undergraduate (UME), graduate (GME), and continuing (CME) medical education as well as healthcare systems are needed[22,23]; and

WHEREAS, anti-racism is an action-oriented system that seeks to address and bring awareness to racism at many levels[24]; and

WHEREAS, an organization committed to anti-racism seeks to address racism at an institutional level through systemic changes[24]; and

WHEREAS, the University of Louisville (UofL) has established itself as an anti-racism institution across all campuses, and The University of Louisville School of Medicine (ULSOM) has launched an Anti-Racism Task Force to make improvements to UME such as curriculum language changes and immediate student reporting systems for racism in the learning environment[25]; and

WHEREAS, both UME and GME are also supported by the Cardinal Anti-Racist Agenda (CARA) committees that design research, craft policies, prepare trainings, and develop other materials to reduce racism across ULSOM[25,26]; and

WHEREAS, the AMA MSS has a policy (295.194MSS) supporting anti-racism competencies in undergraduate medical education, and the AMA has a policy (H-65.925) supporting programs that engender greater understanding and prevention of racism in UME, GME, and CME; now, therefore, be it

RESOLVED, that the KMA encourages members to look at historical structural racism in medicine and have an open discussion about its continuing ramifications; and be it further

RESOLVED, that the KMA amend the Equality Act policy adopted in 2019 to read "KMA opposes discrimination on the basis of race, ethnicity, color, religion, national origin, disability, income, education, social status, geographic factors, ~~sex,~~ sexual orientation, and gender identity"; and be it further

RESOLVED, that the KMA amend the Equality and Fairness in Delivery of Medical Care policy last changed in 2019 to read "Disparities in the delivery and rendering of medical care, whether based upon race, sex, sexual orientation, gender identity, income, education, social, cultural or geographic factors, are unjustifiable and must be eliminated. Physicians should examine their practices to ensure that prejudices and biases do not inadvertently affect clinical judgment in medical care. KMA supports the position that resources for medical research should be distributed in a manner, which promotes the health of all individuals without regard to race, sex, sexual orientation, or gender identity, income, education, social, cultural or geographic fact~~ors~~ to the greatest extent possible"; and be it further

RESOLVED, the KMA advocates for research to explore both patient, student, physician, staff, and leadership perspectives on ways to improve access to equitable care for all persons in the Commonwealth of Kentucky; and be it further

RESOLVED, the KMA encourages medical schools throughout Kentucky to implement anti-racism programs, practices, and curriculum.

References:

[1] Gee GC, Ford CL. STRUCTURAL RACISM AND HEALTH INEQUITIES: Old Issues, New Directions. *Du Bois Rev*. 2011;8(1):115-132. doi:10.1017/S1742058X11000130 https://www.cacgrants.org/assets/ce/Documents/2019/FourLevelsOfRacism.pdf

[2] *2017 Health Equity Report: Uncovering the Root Causes of Our Health*. Louisville Department of Public Health and Wellness; 2017. Accessed July 24, 2021. https://louisvilleky.gov/government/center-health-equity/health-equity-report

[3] Braveman P, Gottlieb L. The Social Determinants of Health: It's Time to Consider the Causes of the Causes. *Public Health Rep*. 2014;129(Suppl 2):19-31.

[4] Abrams EM, Szefler SJ. COVID-19 and the impact of social determinants of health. *Lancet Respir Med*. 2020;8(7):659-661. doi:10.1016/S2213-2600(20)30234-4

[5] Walker RJ, Strom Williams J, Egede LE. Influence of Race, Ethnicity and Social Determinants of Health on Diabetes Outcomes. *Am J Med Sci*. 2016;351(4):366-373. doi:10.1016/j.amjms.2016.01.008

[6] Walker RJ, Smalls BL, Campbell JA, Strom Williams JL, Egede LE. Impact of social determinants of health on outcomes for type 2 diabetes: a systematic review. *Endocrine*. 2014;47(1):29-48. doi:10.1007/s12020-014-0195-0

[7] Gurin P, Dey E, Hurtado S, Gurin G. Diversity and Higher Education: Theory and Impact on Educational Outcomes. *Harvard Educational Review*. 2002;72(3):330-367. doi:10.17763/haer.72.3.01151786u134n051

[8] Whitla DK, Orfield G, Silen W, Teperow C, Howard C, Reede J. Educational benefits of diversity in medical school: a survey of students. *Acad Med*. 2003;78(5):460-466. doi:10.1097/00001888-200305000-00007

[9] Workforce I of M (US) C on I and P-LS for I the D of the USH, Smedley BD, Butler AS, Bristow LR. *In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce.* National Academies Press (US); 2004. Accessed July 23, 2021. http://www.ncbi.nlm.nih.gov/books/NBK216011/

[10] Louie P, Wilkes R. Representations of race and skin tone in medical textbook imagery. *Social Science & Medicine*. 2018;202:38-42. doi: 10.1016/j.socscimed.2018.02.023

[11] Martin GC, Kirgis J, Sid E, Sabin JA. Equitable imagery in the preclinical medical school curriculum: findings from one medical school. *Academic Medicine*. 2016;91(7):1002-1006. doi: 10.1097/ACM.0000000000001105

[12] Diaz T, Navarro JR, Chen EH. An Institutional Approach to Fostering Inclusion and Addressing Racial Bias: Implications for Diversity in Academic Medicine. *Teaching and Learning in Medicine*. 2020/01/01 2020;32(1):110-116. doi: 10.1080/10401334.2019.1670665

[13] DeLisa JA, Lindenthal JJ. Commentary: reflections on diversity and inclusion in medical education. *Academic Medicine*. 2012;87(11):1461-1463. doi: 10.1097/ACM.0b013e31826b048c

[14] Olsen LD. The conscripted curriculum and the reproduction of racial inequalities in contemporary US medical education. *Journal of health and social behavior*. 2019;60(1):55-68. doi: 10.1177/0022146518821388

[15] Cohen JJ, Gabriel BA, Terrell C. The Case For Diversity In The Health Care Workforce. *Health Affairs*. 2002;21(5):90-102. doi:10.1377/hlthaff.21.5.90

[16] Herring C. Does Diversity Pay?: Race, Gender, and the Business Case for Diversity. *Am Sociol Rev*. 2009;74(2):208-224. doi:10.1177/000312240907400203

[17] Gomez LE, Bernet P. Diversity improves performance and outcomes. *Journal of the National Medical Association*. 2019;111(4):383-392. doi:10.1016/j.jnma.2019.01.006

[18] Diversity in Medicine: Facts and Figures 2019. AAMC. Accessed July 23, 2021. https://www.aamc.org/data-reports/workforce/report/diversity-medicine-facts-and-figures-2019

[19] AAMC FACTS & FIGURES 2016. AAMC. Accessed July 23, 2021. https://www.aamcdiversityfactsandfigures2016.org/report-section/section-3/../../report-section/section-3/

[20] *Altering the Course: Black Males in Medicine*. AAMC. Accessed July 23, 2021. https://store.aamc.org/altering-the-course-black-males-in-medicine.html

[21] *The State of Diversity and Inclusion in the Healthcare Industry*. Diversity Best Practices Accessed July 23, 2021. https://www.diversitybestpractices.com/sites/diversitybestpractices.com/files/attachments/2017/10/healthcare_industry_report_overview.pdf

[22] Feagin J, Bennefield Z. Systemic racism and US health care. *Social science & medicine*. 2014;103:7-14. doi: 10.1097/ACM.0000000000002779

[23] Tsai J, Ucik L, Baldwin N, Hasslinger C, George P. Race matters? Examining and rethinking race portrayal in preclinical medical education. *Academic Medicine*. 2016;91(7):916-920. doi: 10.1097/ACM.0000000000001232
[24] Hassen N, Lofters A, Michael S, Mall A, Pinto AD, Rackal J. Implementing Anti-Racism Interventions in Healthcare Settings: A Scoping Review. *International Journal of Environmental Research and Public Health*. 2021;18(6):2993. doi:10.3390/ijerph18062993
[25] Cardinal Anti-Racism Agenda — Office of the President. Accessed July 24, 2021. https://louisville.edu/president/special-programs-initiatives/cardinal-anti-racism-agenda/
[26] Afolabi T, Borowsky HM, Cordero DM, et al. Student-led efforts to advance anti-racist medical education. *Academic Medicine*. 2021;96(6):802-807. doi: 10.1097/ACM.0000000000004043