



Organizational Strategic Plan to **Embed Racial Justice and Advance Health Equity**



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Preamble



The AMA's Strategic Plan to embed equity is a work product led by the Center for Health Equity and informed by subject matter experts internally but also by those distinguished in this field externally (listed on Pages 80-82). Although equity in general and health equity are not new scientific fields, they may seem new to many readers without previous exposure or deep engagement in this work.

As with other scholarly domains, the field of equity has developed a parlance which conveys both authenticity, precision, and meaning. Just as the general parlance of a business document varies from that of a physics document, so too is the case for an equity document. Consequently, as one would expect, the parlance of equity is manifest in this plan. One example is the use of the invocation-like recognition of “land and labor acknowledgement” as exemplified by the italicized statement that appears on the next page. It is common that discussions in the field of equity begin with the recognition that our current state was built on the land and labors of others in ways that violated the fundamental principles of equity. Another distinction of the equity field, which essentially is an extension of this land and labor acknowledgment, is to initiate discussion with recognition of the specific harms of the past including those of the more recent past (termed “truth and reconciliation”). The logic, of course, is that the quest for equity requires reconciliation of past harms but such reconciliation would be impossible without knowing the truths of the past in the clearest of terms. For these reasons, as reflected in the outline, the plan is prefaced first by a background/history section, and then by a section outlining considerations and methods applicable to achieving equity.

Vision for equity and justice in medicine



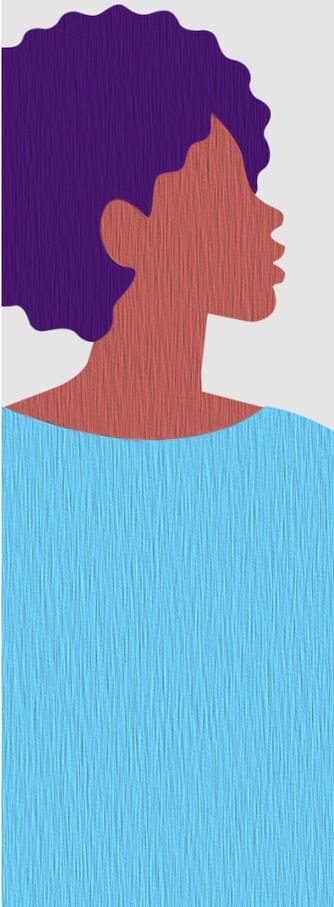
Land and Labor Acknowledgement:

We acknowledge that we are all living off the taken ancestral lands of Indigenous peoples for thousands of years. We acknowledge the extraction of brilliance, energy and life for labor forced upon people of African descent for more than 400 years. We celebrate the resilience and strength that all Indigenous people and descendants of Africa have shown in this country and worldwide. We carry our ancestors in us, and we are continually called to be better as we lead this work.

**WE ARE
ALL BORN
EQUAL.**

**HEALTH IS
OUR HUMAN
RIGHT.**

Our AMA's Center for Health Equity imagines a new way forward for the AMA and U.S. health care that values people equally and treats them equitably. We envision a nation in which all people live in thriving communities where resources work well; systems are equitable and create no harm nor exacerbate existing harms; where everyone has the power, conditions, resources and opportunities to achieve optimal health; and all physicians are equipped with the consciousness, tools and resources to confront inequities and dismantle white supremacy, racism, and other forms of exclusion



and structured oppression, as well as embed racial justice and advance equity within and across all aspects of health systems.

Our bold and necessary path forward seeks to pivot from ambivalence to urgent action; from euphemisms to explicit conversations about power, racism, gender and class oppression, forms of discrimination and exclusion; from passive to specific action supported by resource redistribution and infrastructure change; from rationalization and good intentions to a comprehensive analysis of structures, systems, policies and practices leading to real improvement and impact; and from lack of accountability to an active embrace of equity as a core mission and strategy.

In recognizing AMA's past and present power and influence in medicine and health, we commit to accountability towards the goal of eliminating inequities—systematic, preventable and unjust differences—in health for patients, families, providers and communities, as well as tackling the root causes for these differences and preventing new and further harm.

Our plan's release comes amidst the worst pandemic of our lifetime; a divisive presidential election, punctuated by its violent aftermath; a year of sustained protests in response to police brutality and the exposure of the historical harm imposed upon Black people for generations; escalating hate crimes towards Asian communities; deliberate and ongoing family separation at the U.S. border under the Zero Tolerance Policy causing irreparable harm to children; persistent gun violence and, most recently, in the aftermath of our own journal's egregious, harmful error and failure in posting a podcast denying structural racism; keeping old wounds open while new ones form.

Inequities are not new—but these events do elucidate the consequences of individual and systematic injustice in our country. They exposed the symptoms of structural racism, such as neglect and disinvestment in Black, Indigenous and Latinx neighborhoods; forced residential overcrowding; stolen opportunities to build wealth; segregated and inequitable health care systems; and chronic over-policing and police brutality—all of which have continued to cause harm to emotional, mental and physical well-being across generations, and are reconfirming America's stronghold of false notions of hierarchy of value based on gender, skin color, religion, ability and country of origin, as well as other forms of privilege. The resulting inequities are perpetuated and magnified by defaulting to color- and identity-evasive actions and policies.

Equity is not a zero-sum reality that continues to create a set of winners and losers in health. This direction forward requires us to gain the knowledge, skills and behaviors that align with anti-oppressive and anti-racist praxis. We must develop a critical consciousness that seeks truth and acknowledges the historical realities that powerful organizations and structures, rooted in white patriarchy and affluent supremacy such as the AMA, have both intentionally and unintentionally made invisible.

Achieving optimally equitable solutions requires disruption and dismantling of existing norms, collective advocacy and action across sectors and disciplines. **To move forward, we must prioritize and integrate the voices and ideas of people and communities experiencing great injustice and historically excluded, exploited, and deprived of needed resources such as people of color, women, people with disabilities, LGBTQ+, and those in rural and urban communities alike.**

Equity-centered solutions include, and are not limited to:

- Ending segregated health care that is reinforced by payer exclusion
- Establishing national health care equity and racial justice standards, benchmarks, incentives and metrics
- Ending the use of race-based clinical decision models (including calculators)
- Ensuring that augmented intelligence (AI) is free from harmful, biased algorithms
- Eliminating all forms of discrimination, exclusion and oppression in medical and physician education, training, hiring, matriculation and promotion supported by:
 - Mandatory anti-racism, structural competency, and equity-explicit training and competencies for all trainees and staff
 - Publicly reported equity assessments for medical schools and hospitals
- Preventing exclusion of and ensuring just representation of Black, Indigenous and Latinx people in medical school admissions as well as medical school and hospital leadership ranks
- Ensuring equity in innovation, including design, development, implementation and dissemination along with supporting equitable innovation opportunities and entrepreneurship
- Solidifying connections and coordination between health care and public health
- Acknowledging and repairing past harms committed by institutions

This strategic plan outlines our vision and conviction to become a sustainably diverse, multicultural anti-racist organization, that advances equity and justice, contributes to improving outcomes and quality in health care, and closes historical and contemporary inequities in health. This plan represents one step in a much longer journey that re-orientes our AMA and health care around equity.

Finally, we must operate with the urgency of now. Oppression, exclusion, and racism harm and kill, sapping our society of its full potential in all corners, and especially in health.

We cannot do this alone. We welcome others to join us as we will join you.

“These are the times to grow our souls. Each of us is called upon to embrace the conviction that despite the powers and principalities bent on commodifying all our human relationships, we have the power within us to create the world anew.”

—Grace Lee Boggs, human rights leader, activist, and daughter of Chinese immigrants, *Seeds of Change*¹

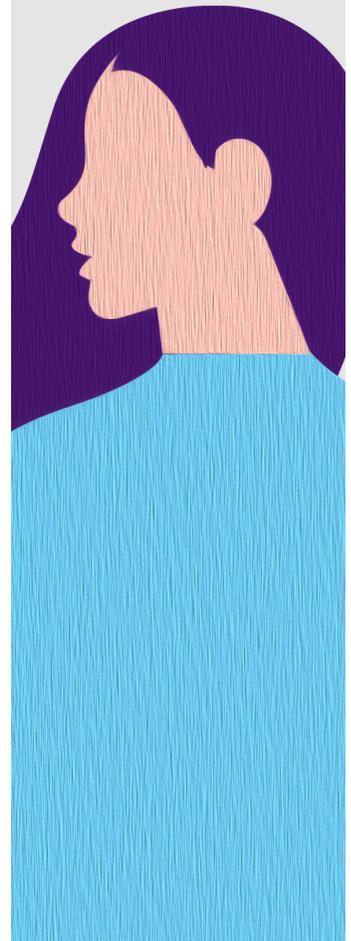
Executive summary



*The American Medical Association is the nation's largest professional association of physicians. We are a unifying voice and we are physicians' powerful ally in patient care. Fulfilling our AMA's mission **to promote the art and science of medicine and the betterment of public health** requires an unwavering commitment to equity and a comprehensive strategy for embedding racial and social justice within our organization and domains of influence. Advancing health equity through our AMA's efforts entails a dedicated, coordinated and honest approach. It recognizes the harmful effects of our past and targets the systemic inequities in our health care system and other social institutions. And it charts a path toward a more promising and equitable future for all. This is AMA's first strategic plan dedicated to embedding racial justice and advancing health equity.*

The origins of this strategic plan date back to the AMA's Annual House of Delegates meeting in June of 2018. In this meeting, the time-limited Health Equity Task Force—appointed by the chair of the AMA Board of Trustees—presented to the AMA House of Delegates Board Report 33, A-18, a “Plan for Continued Progress Toward Health Equity D-180.981.” The report included a definition for “health equity,” an initial framework that outlined the AMA's role in addressing inequities in health care, as well as the recommendation “to develop an organizational unit, e.g., a Center or its equivalent, to initiate, facilitate, coordinate and track AMA health equity activities.” The report and its recommendations were adopted as AMA policy.

In April of 2019, the AMA launched the AMA Center for Health Equity with the hiring of its first Chief Health Equity Officer. The AMA Center for Health Equity is



charged with identifying ways to dismantle racism in our health system as well as facilitating, strengthening and amplifying the AMA's work to eliminate health inequities rooted in historical and contemporary injustices and discrimination.

With the input of many both inside and outside of AMA, this strategic plan serves as a three-year roadmap to plant the initial seeds for action and accountability to embed racial justice and advance health equity for all of our years to come. We will initiate and aggressively push forward the following five strategic approaches:

1 Embed racial and social justice throughout the AMA enterprise culture, systems, policies and practices

- Build the AMA's capacity to understand and operationalize anti-racism equity strategies via training and tool development
- Ensure equitable structures, processes and accountability in the AMA's workforce, contracts and budgeting, communications and publishing
- Integrate trauma—informed lens and approaches when developing and implementing policies and practices
- Assess organizational change (culture, policy, process) over time

2 Build alliances and share power with historically marginalized and minoritized* physicians and other stakeholders

- Develop structures and processes to consistently center the experiences and ideas of historically marginalized (women, LGBTQ+, people with disabilities, International Medical Graduates) and minoritized (Black, Indigenous, Latinx, Asian and other people of color) physicians
- Establish a coalition of multidisciplinary, multisectoral equity experts in health care and public health to collectively advocate for justice in health

3 Push upstream to address all determinants of health and the root causes of inequities

- Strengthen physicians' knowledge of public health and structural/social drivers of health and inequities
- Empower physicians and health systems to dismantle structural racism and intersecting systems of oppression
- Equip physicians and health systems to improve services, technology, partnership and payment models that advance public health and health equity

4 Ensure equitable structures and opportunities in innovation

- Embed racial justice and health equity within existing AMA health care innovation efforts
- Equip the health care innovation sector to advance equity and justice
- Center, integrate and amplify historically marginalized and Black, Indigenous, Latinx and people of color who are health care investors and innovators
- Engage in cross-sector collaboration and advocacy efforts

* Minoritized groups are those that belong to a group or population that has been historically considered a minority by what they are not and the lack of some characteristic by those in the dominant category. This definition, as opposed to minority, emphasizes the process of minoritizing others relative to these socially defined criteria that oppresses groups based on a given social standing: race/ethnicity, immigration status and primary language amongst others.

Marginalized groups are those that have been traditionally underserved and excluded groups. Marginalization occurs through a process of social, economic, and educational deprivation through intentional disinvestment and exclusion for members of a particular group relative to socially defined criteria and conditions such as age, gender, sexual orientation, and disability.

Groups can be both minoritized and marginalized based on different circumstances. And individuals may belong to more than one of these groups and be multiply minoritized and/or marginalized.

5 Foster pathways for truth, racial healing, reconciliation and transformation for the AMA's past

- Amplify and integrate often “invisible-ized” narratives of historically marginalized physicians and patients in all that we do
- Quantify the effects of AMA policy and process decisions that excluded, discriminated and harmed
- Repair and cultivate a healing journey for those harms

We will have great focus on embedding racial justice and equity across the AMA's other strategic arcs of removing obstacles to patient care, preventing chronic disease, confronting the nation's greatest public health crises, and ensuring optimal health for all. As a national leader in health care, it is incumbent on us to lean into our influence and play a more prominent role in the current national reckoning on equity and justice both by using our existing assets—relationships, training platforms, programs, advocacy, communication and marketing infrastructure—and creating new assets as levers for change. It is essential that we also simultaneously maintain a level of awareness and responsiveness when harmful emerging issues arise that can impede the AMA's progression to advance health equity across our AMA enterprise. Lastly, measuring transformation for equity and justice is complex and nascent. Our measurement of success and impact will employ standard and emerging quantitative and qualitative tools as well as give space and grace to embrace that all things cannot be and should not be measured.

Getting to equity and justice necessitates a sense of urgency and ambition. This is not just the work of the Center for Health Equity; rather, it is the responsibility of all of AMA leadership and stakeholders in collaboration with many others. We understand that organizational cultural change work is, at times, unpredictable and may require unexpected pivots in our outlined approaches, actions and accountability along the way. Even with pivots, our focus must consistently understand the impact of our decisions, ensure that we show up cognizant of our power and assume with great responsibility and humility to listen, learn, and act, and to remember our fundamental responsibility to do no harm.

We see tremendous opportunities in our present history for alignment and change in medicine and our country to name, embed and advance racial and social justice. Therefore, capitalizing on these “open doors” in medicine and government is imperative at this moment. History tells us that windows of opportunity for structural, institutional and systemic change for racial justice close as political pendulums swing. Since the doors right now are open, we all—not just historically marginalized physicians—must push as fast and as far as we can.

“The generation to which the present writer belongs may be likened to the offensive linemen on a football team. They have to be rugged, tough and determined. They get banged and battered. Their job is to make holes for fastbacks to run through. If the backs are not there, the holes close up... Even when the backs are there, they have to fight their way for all yardage gained. So it is for young Black physicians today.”

—Montague Cobb, MD, Former President of the National Medical Association and Founding Editor of the *Journal of National Medical Association*²



Section 1
Background and history



Getting on the same page: An equity primer



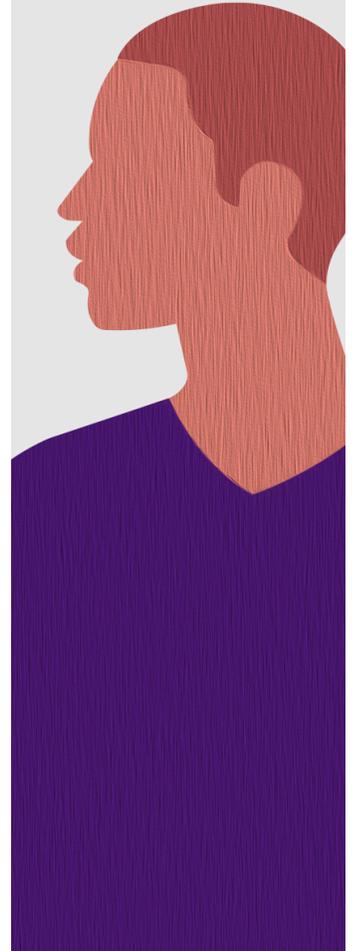
Understanding that we all come to equity and justice with potentially different life experiences and levels of understanding of the existing historical context, evidence, theory and practice, this section grounds our members and readers in common definitions, concepts and frameworks. This primer is not exhaustive but, rather, more of an introduction. We recognize that there are other useful and valid ways to explain the concepts that follow, and that language evolves over time. We encourage further investigation, engagement and reflection to expand one's knowledge.

Equality, equity and justice distinctions

While we, philosophically, have intrinsic and “equal” value resulting from our shared humanity, it is the lottery of birth that arbitrarily defines the conditions, environments and opportunities that largely shape our life experiences and outcomes. We operate in a carefully designed and maintained system that normalizes and legitimizes an array of dynamics—historical, cultural, institutional and interpersonal—over time that routinely advantage white (also wealthy, hetero-, able-bodied, male, Christian, U.S.-born) people at the expense of Black, Latinx, Indigenous and people of color (also low wealth, women, people with disabilities, non-Christians, and those foreign-born) and that is currently reinforced by policies that are blind to power (political and financial) imbalances and realities.^{3,4}

Equality

Equality as a process means providing the same amounts and types of resources across populations. Seeking to treat everyone the “same,” ignores the historical legacy of disinvestment and deprivation through historical policy and practice of marginalizing and minoritizing



communities. It has generated unequal society that traces back prior to the founding of our country.

Through systematic oppression and deprivation from genocide, forced removal from land and slavery, Indigenous and Black people have been relegated to the lowest socioeconomic ranks of this country. The ongoing xenophobic treatment of undocumented Brown people and immigrants is another example.⁵ Thus, intergenerational wealth has mainly benefited and exists for white families.

The “equality” framework, as applied, also fails individual patients and communities. For example, high-quality and safe care for a person with a disability does not translate to ‘equal’ care. A person with low vision receiving the ‘same’ care might receive documents that are illegible, depriving them of the ability to safely consent to and participate in their own treatment. Equality fails when applied to other domains, including language, health literacy and transgender health.

The resulting differences in outcomes among historically marginalized and minoritized populations have been explained away through the myth of meritocracy. It is a narrative that attributes success or failure to individual abilities and merits. It does not address the centuries of unequal treatment that have intentionally robbed entire communities of the vital resources needed to thrive.

Equity

Where equality is a blunt instrument of “sameness,” equity is a precise scalpel that requires a deep understanding of complex dynamics and systems with skill and practice in application.

The World Health Organization defines health equity as the “absence of unfair and avoidable or remediable differences in health among social groups.”⁶ It calls for just opportunities, conditions, resources and power for all people to be as healthy as possible. This requires the elimination of obstacles to health, such as poverty, discrimination and their consequences, including perceived and real powerlessness and lack of access to good jobs with equitable pay, good quality education and housing, safe neighborhoods, and high quality and safe health care that is easily accessed.

Health inequities are “unjust, avoidable, unnecessary and unfair” gaps that are neither natural nor inevitable.^{7,8} Rather, they are produced and sustained by deeply entrenched systems that intentionally and unintentionally silence, cause stress and prevent people from reaching their full potential. Inequities cannot be understood or adequately addressed if we focus only on individuals, their behavior or their biology.^{9,10}

Equity can be understood as both a process and an outcome. It involves sharing power with people to co-design interventions and investing and redistributing resources to the greatest need—with explicit consideration for how racism, gender and class oppression, ableism, xenophobia and English language supremacy impact outcomes.

Justice

**“People ask me sometimes, when do you think it will
it be enough? When will there be enough women on the
court? And my answer is when there are nine.”**

—Justice Ruth Bader Ginsburg, U.S. Supreme Court Justice
and gender equality and civil rights advocate¹¹

Justice describes a state where the dismantling of structural and systemic inequities (and the laws and policies that sustain them) is not only achieved, but new structures and systems are instituted that deliberately reinforce their elimination. Justice and equity are interconnected but justice maintains equity through preventive measures that are rooted in a core understanding of how social injustice functions, foundationally protecting historically marginalized and minoritized peoples. It is an achievable goal that requires the sustained focus, investment and energy of people in positions of power being accountable to communities they serve. It necessitates a redesign of our structures, policies and practices to deliver the high-quality and safest possible conditions that allow for everyone to reach their highest potential and prevent one's identity from determining the course of their life.

Race is a social (not biologic) construct

“But race is the child of racism, not the father. And the process of naming ‘the people’ has never been a matter of genealogy and physiognomy so much as one of hierarchy. Difference in hue and hair is old.”

—Ta-Nehisi Coates, author and journalist, *Between the World and Me*¹²

As outlined by the November 2020 AMA policies entitled “Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice,” and “Racial Essentialism in Medicine,” our AMA confirms race as a social construct (see *Appendix 1*). Race is a socially constructed way of grouping people, based on skin color and other apparent physical differences. It has been defined by an arbitrarily organized combination of physical traits, geographic ancestry, language, religion and a variety of other cultural features.

Social definitions of race differ depending on context, but they always operate in the service and self-interests of social-dominance hierarchies, thus benefitting white individuals—those with the greatest power politically, financially and racially.¹³ The false notion of hierarchy of human value based on skin color still prevails. White supremacy, constantly adapting to legal and cultural challenges, persists in part by the way many whites ignore their whiteness to the point of invisibility, their role in a racial hierarchy, and the privilege it gives them. A myth of innocence, an assumption of objectivity and other rationalizing devices, supports an unwillingness to recognize or reckon with racial injustice. Social codes, “othering” people who are not white, and the threat of violence or its anticipation play a role in supporting white supremacy.

Race and ethnicity are often used interchangeably in our society, although they do not mean the same thing. Categories of race and ethnicity have changed over time, usually based on what supports the political, financial and self-interests of white men, those historically most powerful.¹⁴

Ethnicity is a socially constructed way of grouping. It emphasizes national origin, language, culture, religion, geography and/or family origin. In contrast to race, ethnicity encompasses various racial backgrounds. Since 1980, the U.S. Census introduced the category “Hispanic” on all forms as an ethnicity; prior to that, the category was “Mexican.” This also accounts for the impact of the global colonization that created cultures and communities of multiple identities. People of Latinx, Latino/a and/or Hispanic backgrounds can be of any race (e.g.,

Black, white, Indigenous/Native American Asian, or identify with multiple more races). Ethnicity also operates based on context, and in service of social-dominance hierarchies.

In contrast, genetic or biologic ancestry is the proportion of recent ancestry displayed in an individual via genetic material inherited from one's ancestral geographic origins. The modern consensus of experts is that our species does not have enough genetic variability among its populations to justify either the identification of geographically based races or evolutionarily distinct lineages.

Race was manufactured by humans. It is a poor proxy for genetic ancestry and has been consistently used to legitimize the preferential treatment of whites over others. While race may be a social construct, *racism* has devastating impacts on the bodies of people of color (see Appendix 2 for additional definitions). It is more appropriate and accurate that “clinicians and researchers focus on genetics and biology, the experience of racism, and social drivers of health inequities—and not race—when describing risk factors for disease.”¹⁵ Such focus must be further grounded in a shared understanding of critical concepts, which underline the structures of power in which this social construct endures.

“The truth is, our nation’s investment in racism, capitalism, and white supremacy shredded our safety net, almost cost us our democracy, and stole many of our loved ones’ lives. In the middle of our loneliest year, our dependence on each other—for public education, public health, public utilities, and public recreation—was the truth buried beneath our pain. As we begin to slowly emerge from the depths of this plague, how we make sense of that truth will determine our future.”

—Rhea Boyd, MD, pediatrician, public health advocate and scholar, *On Shame and Healing*¹⁶

Racism

Racism, as defined by Camara Jones, MD, MPH, PhD, is a “system of structuring opportunity,” which assigns value based on race, disadvantaging people of color while offering advantage to whites, hindering the realization of the “full potential of the whole society through the waste of human resources.”¹⁷ In order to center this definition, we must acknowledge the different levels under which racism exists and prevails in our society: structural, institutional, interpersonal and internalized (see Figure 1). We must also recognize, as noted by Lance Gravlee, PhD, that racism is interwoven and consists of linked and mutually reinforcing systems that uphold each other—health care, housing, immigration, education, etc.¹⁸

“Locating white supremacy in *individuals*, rather than in structures, is how the shared commitment to white ignorance preserves one’s sense of self while allowing oppressive structures to persist.”

—Lance Gravlee, PhD, anthropologist¹⁹

Figure 1. Definitions and Levels of Racism and Related Terms

	Definitions	Notes
Racism	As defined by Camara Jones, MD, MPH, PhD, “racism is a system of structuring opportunity and assigning value based on phenotype (‘race’), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and undermines realization of the full potential of the whole society through the waste of human resources.”	Racism can operate at different levels: structural, institutional, interpersonal, and internalized.
Structural Racism	As defined by Zinzi Bailey et al, structural racism “refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources.”	
Institutional Racism	Discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race.	Individuals within institutions take on the power of the institution when they act in ways that advantage and disadvantage people, based on race.
Interpersonal Racism	The expression of racism between individuals. These are interactions occurring between individuals that often take place in the form of harassing, racial slurs, or racial jokes.	It may also take more subtle forms of unequal treatment, including micro-aggressions.
Internalized Racism	Acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth.	
Prejudice	An unfavorable opinion or feeling formed beforehand or without knowledge, thought, or reason.	Prejudice also means an action in the sense that they are sequential steps by which an individual behaves negatively toward members of another group: verbal antagonism, avoidance, segregation, physical attack, and extermination. The term “prejudice” also refers to unfavorable opinions or feelings which lead groups to view members of other social groups as threatening adversaries who are inherently inferior or are actively pursuing immoral objectives.

	Definitions	Notes
Bias	<p>A form of prejudice in favor of or against one person or group compared with another usually in a way that's considered to be unfair to one group. Biases may be held by an individual, group, or institutions and can have negative or positive consequences and oftentimes are learned behaviors or habitual thoughts. Biases often emerge in relation to race/ethnicity, gender, socioeconomic status, ability status, LGBTQ+ identity, literacy, amongst other groupings.</p> <p>There are two main types of biases²⁰ discussed in scholarly research and in medicine^{21,22} that inhibit progress towards multiculturalism and equity in our society:</p> <ol style="list-style-type: none"> 1. Explicit or Conscious bias—This refers to the attitudes and beliefs we have about a person or group on a conscious level, that is we are aware and accepting of these beliefs, and they are usually expressed in the form of discrimination, hate speech or other overt expressions. 2. Implicit or Unconscious bias—This refers to the unconscious mental process that stimulates negative attitudes about people outside one's own 'in group'. For example, implicit racial bias leads to discrimination against people not of one's own group. Extensive research supports the notion that we all hold unconscious beliefs about various social and identity groups, and these biases stem from one's tendency to organize social worlds by categorizing and are influenced by power dynamics in a society. 	<p>It is important to note that biases, both explicit and implicit, have to be unlearned at the individual, group and institutional level in order to mitigate negative consequences as a result of existing and prevailing biases. Both first require an awareness and acknowledgment that the bias exists and require personal, group and institutional action to eliminate these biases.</p>

Adapted from Lawrence 2004, David Wellman, Jones 2000 and Bailey, et al 2017, Greenwald and Banaji, 1995

“Race matters. Race matters in part because of the long history of racial minorities being denied access to the political process... Race also matters because of persistent racial inequality in society.”

—Honorable Sonia Sotomayor, U.S. Supreme Court justice, born to Puerto Rican family and raised in South Bronx²³

Intersectionality

Leading feminist and social justice theories and practices acknowledge that intersectionality, first coined by Kimberlé Crenshaw,²⁴ as legal terminology to recognize the unique experiences and legal challenges of Black women, whom as a group experienced both racism and sexism. It is the ongoing examination of the overlapping systems of oppression and discrimination that communities face based on race, gender, ethnicity, ability, etc. It is our role to continuously examine the multiple forms and kinds

of intersectional exclusions. The call for an anti-racist health care system is one that recognizes and addresses the intersectionality of systems of oppression every day.²⁵

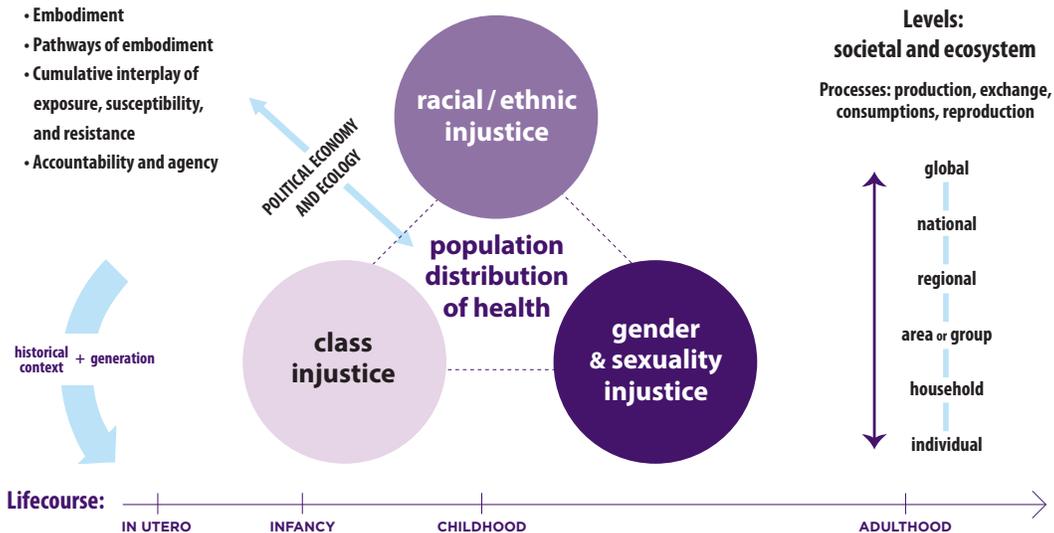
Social and structural drivers of health and moving upstream

The AMA Center for Health Equity uses “social drivers” as an umbrella term to refer to social needs and social determinants of health. “Social needs” refer to individual-level material resources and psychosocial circumstances required for well-being of one’s physical and mental health. “Social determinants of health” interventions address community-level concerns and refers to the underlying community-wide social, economic and physical conditions in which people are born, grow, live, work and age.

“Structural determinants of health equity” address the broader issues of the climate, societal norms, macroeconomic social/health policies, and the systems of power that shape social hierarchy and gradients. According to the National Academies of Science, Engineering, and Medicine, “structural inequities are the personal, interpersonal, institutional, and systemic drivers (*aka root causes, also see Appendix 2 for definition*)—such as, racism, sexism, classism, able-ism, xenophobia, and homophobia—that make those identities salient to the fair distribution of health opportunities and outcomes.”²⁶ “Structural drivers” of health inequity negatively impact social determinants of health for people who have been historically marginalized and ultimately produce health inequities.

Politics and policies greatly influence health.²⁷ Ecosocial theory of disease distribution posits that health inequities exist in relation to power, levels, life course, historical generation, biology and ecosystems (*see Figure 2*).^{28,29} Political decisions directly create the structural and social conditions and characteristics of our environments, either making them more or less healthy. An understanding of the origins of policies and their impact on the distribution of opportunities and resources, equips health care workers to develop and implement actionable solutions to improve health and advance equity. As we learn more about the effects of policy on health, we begin to realize that all policy is health policy.

Figure 2. Ecosocial Theory: Levels, Pathways and Power

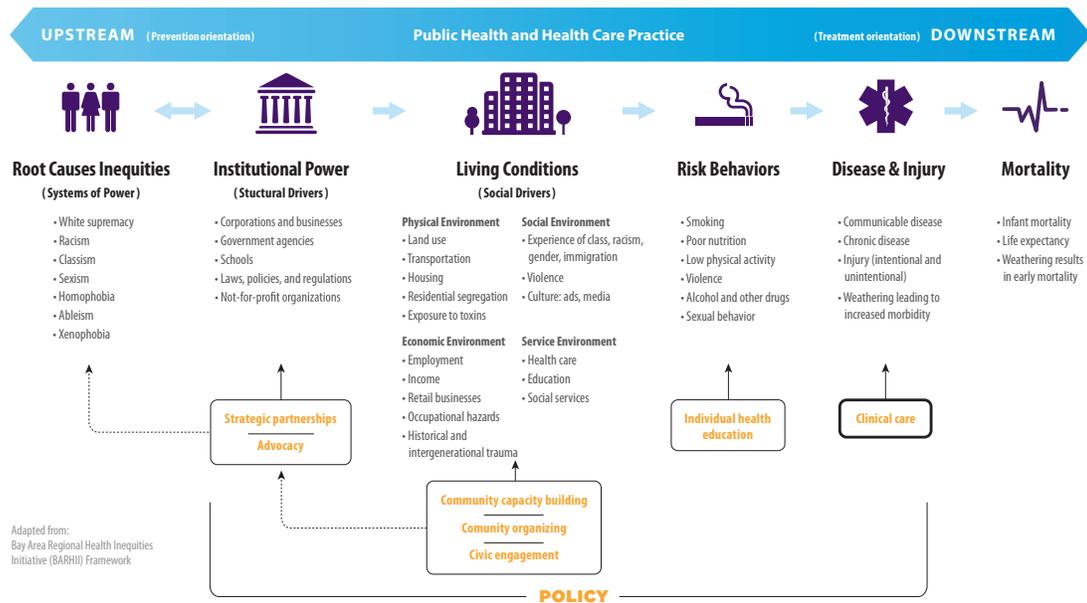


Note: To explain current and changing population distributions of disease, including health inequities, and who and what is accountable for the societal patterning of health, it is necessary to consider causal pathways operating at multiple levels and spatiotemporal scales, in historical context and as shaped by the societal power relations, material conditions, and social and biological processes inherent in the political economy and ecology of the populations being analyzed. The embodied consequences of societal and ecologic content are what manifest as population distributions of and inequities in health, disease, and well-being.

Adapted from: Krieger N. Measures of Racism, Sexism, Heterosexism, and Gender Binarism for Health Equity Research: From Structural Injustice to Embodied Harm—An Ecosocial Analysis. *Annual Review of Public Health* 2020 41:1, 37–62. <https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-040119-094017>

Moving upstream* to address the political, structural and social drivers of health and health inequities, along with working to dismantle the systems of power and oppression that shape these drivers, requires action on the societal, community and individual level (see Figure 3). Structural determinants influence social determinants, which influence an individual's social and material needs. Addressing social and structural drivers of health strengthens health care systems' ability to improve quality across all domains while reducing inequities. To apply this framework, providing food to a patient addresses individual social needs. Yet, addressing the lack of supermarkets by increasing grocery stores in that patient's neighborhood addresses social determinants. And identifying the root causes of food deserts, for example, structural racism, works to provide context to the unjust construction of the structural drivers—the policies and laws that do not lead to adequate investment (see Figure 3).

Figure 3. What Creates Health Framework



* Upstream refers to acknowledging and addressing the structural, societal, community and individual-level factors that influence health. Whereas downstream refers to the dominant approach of treating individual-level factors and/or contributors without wholly addressing structural, societal, and community factors.

Downstream and upstream

The Upstream Parable

Adapted by Rishi Manchanda from a version told by Adewale Troutman

Three friends come to a turbulent river and are alarmed to see people of all ages struggling in the water, approaching a waterfall, crying for help. They jump right in.

The first friend goes straight to rescue those in the most urgent trouble, closest to the waterfall. One by one, she helps people in dire need.

The second friend builds a raft to help those a little farther upstream, to usher more people to safety before they reach critical danger.

But the struggling swimmers keep coming. The two friends, growing exhausted, spot their third friend swimming away from them, far upstream. They shout, "Where are you going? There are more people here to save!"

She shouts back, "I know! I'm going to stop whoever or whatever is throwing these people in the water!"

To advance health equity, our health care workforce needs all three friends: the Rescuers who help when individual patients are acutely and severely ill; the Primary Care Raft Builders, who each help keep many hundreds of people healthy; and the Upstreamists, who help us address the factors that make people sick in the first place (i.e., the social and structural drivers of health inequity) and transform the way we care for patients and build healthy, more just communities.

–Rishi Manchanda, MD, MPH, founder and president of HealthBegins, *The Upstream Doctors*³⁰

The U.S. health care system has long taken a rescue-based and downstream* approach to dealing with the individual-level medical needs of patients.^{31,32} We must understand and work upstream to confront and dismantle the root causes of inequities, and not just apply rescue-based downstream approaches to optimizing health and confronting bad health outcomes and harm.

These root causes provide the lenses through which most of policies and laws—structural drivers—are created. These opportunities are considered structured because they are designed within systems that are mutually reinforcing. They have historically, and up to the present day, been codified into legislation and policies by white male lawmakers across this country. This exclusion robs Black and Brown communities of the conditions, resources, power and opportunities that produce optimal health; it is unjust and avoidable.

The health and non-health behaviors and choices provided to historically marginalized and minoritized communities and people arise from, and are shaped by, these conditions of deprivation and trauma, rather than causing them—as suggested by the myth of meritocracy, and other malignant narratives, that place the burden of responsibility for both harm and repair on oppressed populations. The disproportionate impact of early

* As denoted in the parable and Figure "What creates health," downstream is a traditional approach that focuses on treating individual level issues or causes like behavior change or treatment for illness.

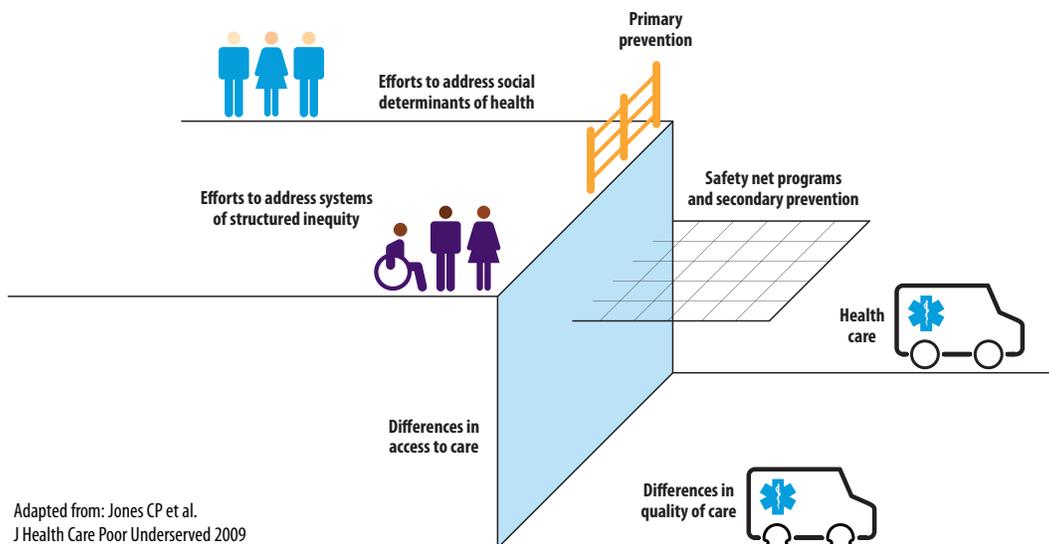
death and morbidity on Black, Latinx* and Indigenous people is rooted in our country's legacy of powerful systems that structure opportunity and assign value that historically advantages whites and oppresses historically minoritized and marginalized communities, thereby setting the foundation for neighborhood and community level social conditions that exist related to housing and education as an example. This is inextricably intertwined with patients' social needs. This legacy determines the type of health outcomes in mortality and morbidity that people and their communities will experience.

This shifting of the health outcomes narrative from *the cause*; solely from the individual and behavioral level to the *causes of causes*, the social and specifically the socioeconomic factors that influence the health narrative at the social and structural levels, is a central priority in health equity work. As anti-racist historian Ibram X. Kendi has argued, "one either believes problems are rooted in groups of people, as a racist, or locates the roots of problems in power and policies, as an anti-racist."³³

The Cliff Analogy

Consider the analogy of a cliff from Camara Jones, MD, MPH, PhD (see Figure 4), which provides a powerful visual depiction of health equity. At the bottom of the cliff is an ambulance, representing the nation's health care system, largely characterized by emergency, tertiary, downstream care. The cliff represents a downward trajectory into illness or disease. The net above the ambulance represents the primary prevention necessary to combat spiraling falls into disease in the first place. The net also represents safety net implements (as secondary prevention) designed to catch people who fall into situations of critical health care need. Health interventions at the community level which account for (or not) social determinants of health either alter the proximity of the population to the edge of the cliff, moving the population to safety (or, adversely, placing it closer to the edge).

Figure 4. The Cliff Analogy



* Latinx is used as the umbrella term intended to be a gender neutral and gender non-binary inclusive term for all people who identify as either Latinx/Latino/Latina or Hispanic. Latinx also is intended to include those who choose to identify with their ethnic or national origin inclusive of the countries in Latin America and of the Caribbean who were colonized by Spain or Portugal. In addition, the term Hispanic also refers to a person who is from or has ancestors from a Spanish-speaking territory or country and is inclusive of Spain.

Dr. Jones's cliff analogy illustrates the structural drivers of health inequity—the systems of oppression and power that systematically advantage some groups (moving them further away from the edge of the cliff, building a sturdier fence, a stronger net and a more efficient ambulance) and disadvantage other groups (moving them to the edge of the cliff, dismantling the fence and the net, and removing the ambulance, under no control of their own).

Dr. Jones's analogy also opens discussions about inequities that exist in the health care system itself—through individual-level biases, prejudices and stereotyping on the part of health care providers,³⁴ racial bias in clinical decision-making support tools,^{35,36} or through policies and systems that limit access to quality treatment and produce inequities in outcomes.³⁷ The effects of each inequity varies but come together to create the ongoing forms of racism we see (*as illustrated in Figure 1*).

Dr. Jones' cliff analogy also signals the fundamental role of structural racism as a foundational system in the United States that patterns opportunity and outcomes. In the cliff image, the green population is close to the edge, at risk of falling over, whereas the red population is safely positioned away from danger. Using an equity lens to dig deep into the “why” is key to understanding the differential lived experience between communities. More and more evidence suggest that answering this question requires deep social examination into the causes of the *causes of health*, illustrated in Figure 3.

Structural violence

“Wars of imperial conquest have not been solely or even mostly waged over the land and its resources, but they have been fought within the bodies, minds and hearts of the people of the earth for dominion over them.”

—Paula Gunn Allen, American Indian scholar and poet, *The Sacred Hoop*³⁸

“Structural violence”, according to Paul Farmer, MD, et al, can be defined as “social arrangements that put individuals and populations in harm’s way. The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people...”³⁹ Structural violence is often a slow violence of living in life-harming conditions, such as removal and displacement from land, racialized segregation, mass incarceration and/or poverty over a lifetime; it is itself both a cause of the cause and an expression of structural violence. And, of course, lifelong experiences of racism and discrimination, which bear on the body in a particularly stressful way, is the ultimate shape of structural violence. This is the process of embodiment illustrated earlier in Figure 2, and defined by Nancy Krieger as: “how we literally incorporate, biologically, the material and social world in which we live, from in utero to death; a corollary is that no aspect of our biology can be understood absent knowledge of history and individual and societal ways of living.”⁴⁰ Over time, social injustices have been literally embodied by Black and Brown communities, creating individual and collective chronic stress and trauma that elevate stress hormones and lead to inflammation that wreaks havoc upon internal organs. In effect, chronic exposure to racism—whether structural, institutional or interpersonal—over the course of one’s lifetime causes “weathering” of peoples’ bodies that increases vulnerability to illness and early death. (*Appendices 3-8 illustrate how structural violence have resulted in structural*

inequities impacting Asian, Black, Indigenous, Latinx, LGBTQ+ community and people with disabilities.)

The landmark World Health Organization Commission on the Social Determinants of Health concluded: “Social injustice is killing people on a grand scale.”⁴¹ This is the basis for adverse childhood experiences (ACEs). ACEs are traumatic experiences that occur during childhood and adolescence.⁴² For decades, evidence has demonstrated the significant correlation between the environments we mature in and our health and well-being later in life.^{43,44} Racism and discrimination are ACEs that activate cascades of biological pathways throughout the life course, ensuring historically marginalized communities remain disproportionately plagued by early disease and abbreviated life.⁴⁵ Therefore, medical interventions across the health care continuum—from integrating anti-racism and structural competency in medical education shifts toward valuing structural public health threats, to incorporating an equity analysis within health insurance coverage designs, to embedding equity into operations, cost-control, quality improvement and safety efforts—must account for the persistent harms associated with structural violence to make true headway in combating avoidable differences in health outcomes.

“To understand the root causes of the pathologies we see today, which impact all of us but affect Brown, Black and poor people more intensely, we have to examine the foundations of this society which began with colonization... Colonization was the way the extractive economic system of Capitalism came to this land, supported by systems of supremacy and domination which are a necessary part to keep wealth and power accumulated in the hands of the colonizers and ultimately their financiers.”

—Rupa Marya, MD, internal medicine specialist, author and advocate,
*Inflamed: Deep Medicine and the Anatomy of Injustice*⁴⁶

The detrimental effects of colonization, racial capitalism, and enduring forms of supremacy, as noted by Rupa Marya, MD, have upheld slavery, genocide, abuse and exploitation of resources. Current systems promote competition and exploitation of natural resources, leading to the destruction or depletion of our physical, emotional and social resources and resulting in the widening inequities for Black, Indigenous and other people of color. This persistent cycle of structural violence contributes to the generational and recurring trauma that negatively affects health and wellbeing.⁴⁷

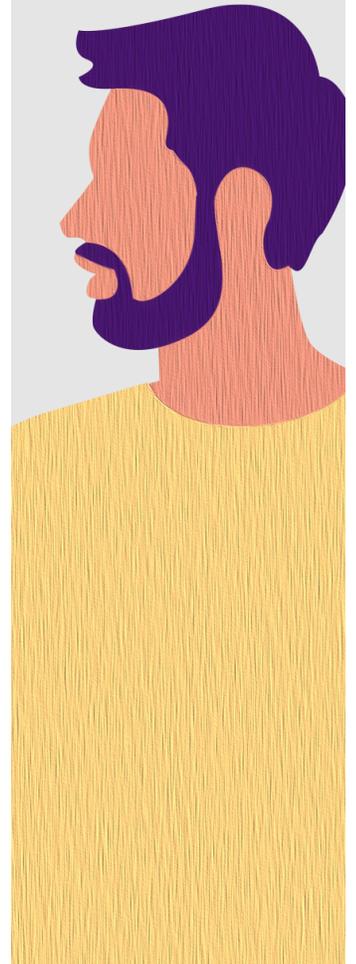
What does it mean for the AMA to center and embed equity?



Our AMA's mission, "To promote the art and science of medicine and the betterment of public health," requires us, as an enterprise, to step into our responsibility to become a leader in health equity, using our resources to advance a more equitable future. The AMA enterprise consists of its members, sections and councils, House of Delegates, the Board of Trustees the management team and employees.

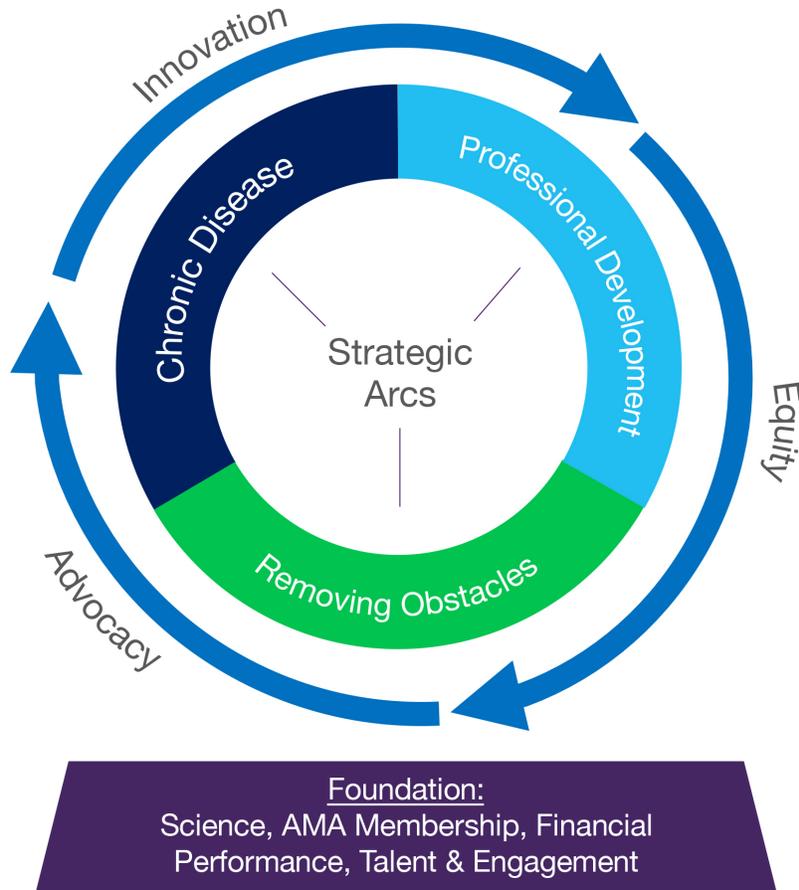
Embedding racial justice and equity at the core of our AMA strategy means we value all people equally and create and sustain an optimal culture that supports effective action and ensures significant impact. We will accomplish this by consistently using lenses of racial, gender, LGBTQ+, disability, class and social justices; naming and disrupting dominant or malignant narratives that obscure the fundamental causes of health inequities; elevating the voices and ideas of those most proximal to experiencing injustice; ensuring systems meet patients' individual-level medical and social needs; advocating for elimination of the social, structural, and political drivers of health inequities and the systems of power and oppression that sustain them; and continually pushing our own perceived boundaries to reimagine a just and liberated future.

At the AMA, values and concepts of equity and justice are intended to be meaningfully integrated throughout the enterprise's strategies, practices, programming, policies and culture. Equity, via explicit goals and performance metrics, is to be visible across all domains of management, membership, innovation, advocacy, workforce, contracting and administrative functions. Thereby equity, as an accelerator, will be used to surface and bring together cross-cutting opportunities within and outside of the AMA, and to more quickly and



effectively drive our work that supports medicine toward a more equitable future, removes obstacles that interfere with patient care and confronts the nation's greatest public health crises (see Figure 5).

Figure 5: Equity, Innovation and Advocacy as AMA-wide Accelerators



AMA and equity— an historical record



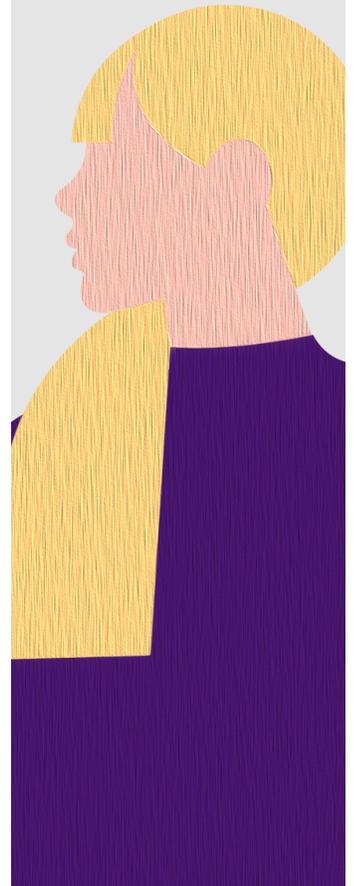
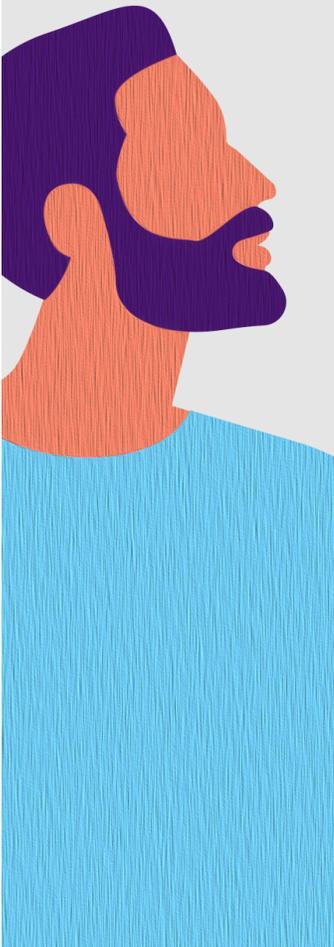
Acknowledging our historical harms (1847–1997)

“But all our phrasing—race relations, racial chasm, racial justice, racial profiling, white privilege, even white supremacy—serves to obscure that racism is a visceral experience, that it dislodges brains, blocks airways, rips muscle, extracts organs, cracks bones, breaks teeth. You must never look away from this. You must always remember that the sociology, the history, the economics, the graphs, the charts, the regressions all land, with great violence, UPON THE BODY.”

—Ta-Nehisi Coates, author and journalist,
*Between the World and Me*⁴⁸

No set of organization-wide commitments to embedding equity and anti-racism can succeed without first initiating an honest accounting of our AMA's past and/or persistent practices that excluded, formally or informally, physicians based on race, ethnicity, gender, sexual orientation, ability and country of origin (i.e., International Medical Graduates), and caused long-standing harm to historically marginalized and minoritized communities. Historically, AMA policies have not always been well-aligned with an equity and justice imperative.

We cannot deny that AMA's past silence on certain health system and policy-related issues has contributed to and had a negative impact on historically marginalized and minoritized communities, and exclusion in medicine more broadly. Furthermore, we recognize the longstanding archival silence that has occurred at the AMA. Archival



silence is the unintentional or purposeful absence or distortion of documentation of enduring value, resulting in gaps and inabilities to represent the past accurately.

Our equity agenda is also reconciliatory. Some health policies have been a critical vehicle, driving inequity in terms of health care access, quality and safety of care delivery, and with respect to distribution of non-medical resources pertinent to other public policy leading to disparate impact on historically minoritized and marginalized communities' ability to achieve optimal health.

While not exhaustive, the following illustrates some of the legacy of such harmful practices or proceedings:

- AMA Transactions published the requirements to practice medicine in the states: In 1849, one of the state medical societies called for all "irregular-bred pretenders," like "Indian Doctors," to be considered illegal practitioners. Though this is a state society policy and not AMA policy, we published this in our official records without question or commentary.⁴⁹ (p. 327)
- In 1871, the official positioning of the President of the AMA, Wilfred Stille, MD, during a formal address to assembled membership, asserted that women are inferior to men in all respects, even though some may technically be qualified as physicians. Stille argued the "woman question" (whether women should be allowed in any field) is a distraction and infects everything in this time period. He said, it "raves at political meetings, harangues in the lecture-room, infects the masses with its poison, and even pierces the triple brass that surrounds the politician's heart."⁵⁰ Stille also argued that women may be able to care for others, but their nature (as women) inherently prevents them from achieving the powers of intellect and discernment necessary for physicians. "The laws of nature are eternal and immutable. The law which makes man the father and woman the mother of children impresses upon both [men and women] characters which are inseparable from their functions and determine their relative positions in the world; gives government to the one and subordination to the other; to the one intellect, to the other heart."⁵¹
- In 1876, J. Marion Sims served as president of the AMA. Long heralded as the "father of modern gynecology," the historical record clearly shows that his renowned medical innovations were developed through countless rounds of non-anesthetized vaginal surgical experimentation. Sims's procedures, upon women who were enslaved—at least three of whom were named Lucy, Anarcha and Betsey, as documented in his own autobiography. His procedures catapulted him to fame and influence early in his career. His work caused immeasurable suffering on his "subjects" and reinforced essentially racist misconceptions in medical science, specifically regarding the biological differences of feeling pain between Blacks and whites that still persist to this date.

- From the 1870s through the early 19th Century, two Washington, D.C., medical societies sent rival delegations to the AMA's national meetings: an all-white delegation from one medical society and an integrated delegation from a medical society led by physicians from Howard University. The integrated delegation was twice excluded from the meetings of the AMA House of Delegates, while the all-white society's delegates were admitted. AMA leaders voted to devolve the power to select delegates to individual state societies, thereby tacitly accepting racial segregation of constituent societies. This eventually forced African American physicians to create their own organizations, including the National Medical Association in 1895. AMA's decision 25 years before *Plessy v Ferguson*, made the association a model of how to accomplish racial segregation in a national organization by allowing racial segregation decisions to devolve to local components.
- The National Medical Association was steadfast in its attempts to persuade the AMA to take action against racially discriminatory membership practices throughout its constituent state and county societies. Exclusion from AMA membership created direct barriers to specialty training and professional development for Black physicians, directly harming minoritized communities who suffered from a dearth of access to qualified physicians. For example, in 1931, there were 25,000 subspecialty trained physicians in the United States, and only two of them were Black: Daniel Hale Williams, MD, and William Harry Barnes, MD.
- In 1901, the *Journal of the American Medical Association (JAMA)* published an article supporting The Chinese Exclusion Act. "The Chinese Exclusion Act is to be up before the coming Congress, and for sanitary reasons it is to be hoped that it will be re-enacted." Rationale for this included that "we have to protect ourselves. That this is a Christian country, and we regard them as heathen, should not make us altruistic to our harm."
- The AMA-supported Flexner Report (1910) issued critical recommendations, which transformed medical education, and conferred guidelines that determined the closure of all but three women-only medical schools and two African American medical schools across the nation. Consequently, the Flexner Report cemented in place a Black medical education and health care delivery system that was separate, unequal, under-resourced, and destined to be insufficient to meet the needs of African Americans, nationwide. For women, this also had a devastating impact. In 1915, 2.9 percent of medical school graduates were women. By 1930, only one women-only medical school remained. The enrollment trend rate for women remained under 5 percent until the 1970s.
- As far back as the 1840s, there were several references in AMA documents to diseases attributed to "Jew peddlers."⁵² Jews at one point in history were racially categorized as non-white until the mid-1930s and were categorized as white. And it is also well known that one of the many indirect results of the Flexner Report was a tightening of medical school admissions, which led to quotas on how many Jews could attend. Morris Fishbein, MD, editor of *JAMA* at the time, admitted in 1939 that Jewish boys applying to medical schools were turned down, "simply because they were Jewish," but he justified this on the basis that they already represented 15 to 20 percent of American doctors."^{53,54}
- Beginning in 1906, our AMA's American Medical Directory, which lists all U.S. physicians, officially marked African American doctors with the notation for "colored."⁵⁵

- In 1939, the AMA appointed a committee to consider “the welfare of colored physicians.” While the AMA decried racial discrimination in state and local society membership, it concluded that every “medical society has the right of self-governance” in membership. Such a contradictory stance rendered moot the intended impact of its overall declaration.
- Between 1940 to 1964, many attempts to change discriminatory AMA membership policies and practices were rejected by the AMA House of Delegates. For example, in 1944, NMA members requested “associate membership” in the AMA—the AMA expressly denied this request. Nearly 20 years later, in 1963, another policy proposal was presented. This time it called for the exclusion of state societies that touted discriminatory membership policies—this, too, AMA leadership and delegates rejected.
- During the 1960s Civil Rights era, in spite of being petitioned by the Medical Committee for Civil Rights to (i) admonish segregationist practices in health care systems to shut down any society which operated by racial exclusionary practices; (ii) oppose the 1946 Hill-Burton “separate but equal” Act; and (iii) oppose accreditation or reaccreditation of non-integrated hospitals, our AMA did not support any of these efforts, nor did our AMA support African American physicians who fought for legal remedies to hospital segregation.

We recognize these events as pivotal watershed moments affecting many historically marginalized and minoritized groups, not all, and primarily race-based, and acknowledge these are not exhaustive of all the ways in which the AMA may have contributed to health inequities and are perpetuating harms, even to this day. *(Please see Appendix #9 for more in-depth overview of past AMA harms to different marginalized and minoritized communities and/or physician groups.)* As we set out, our organizational strategy to drive medicine forward with an equity lens, we must excavate and re-examine our deep past so as not to make the same, or like, grave, tragic and deadly errors. This work is extensive, and we remain committed to uncovering the harm done to marginalized groups. Let us be clear that harms to historically marginalized and minoritized groups do not exist in a time capsule and persist to this date.

Therefore, in parallel, we are working extensively to name and reconcile present day harms caused by AMA policies and actions.

AMA efforts to advance equity



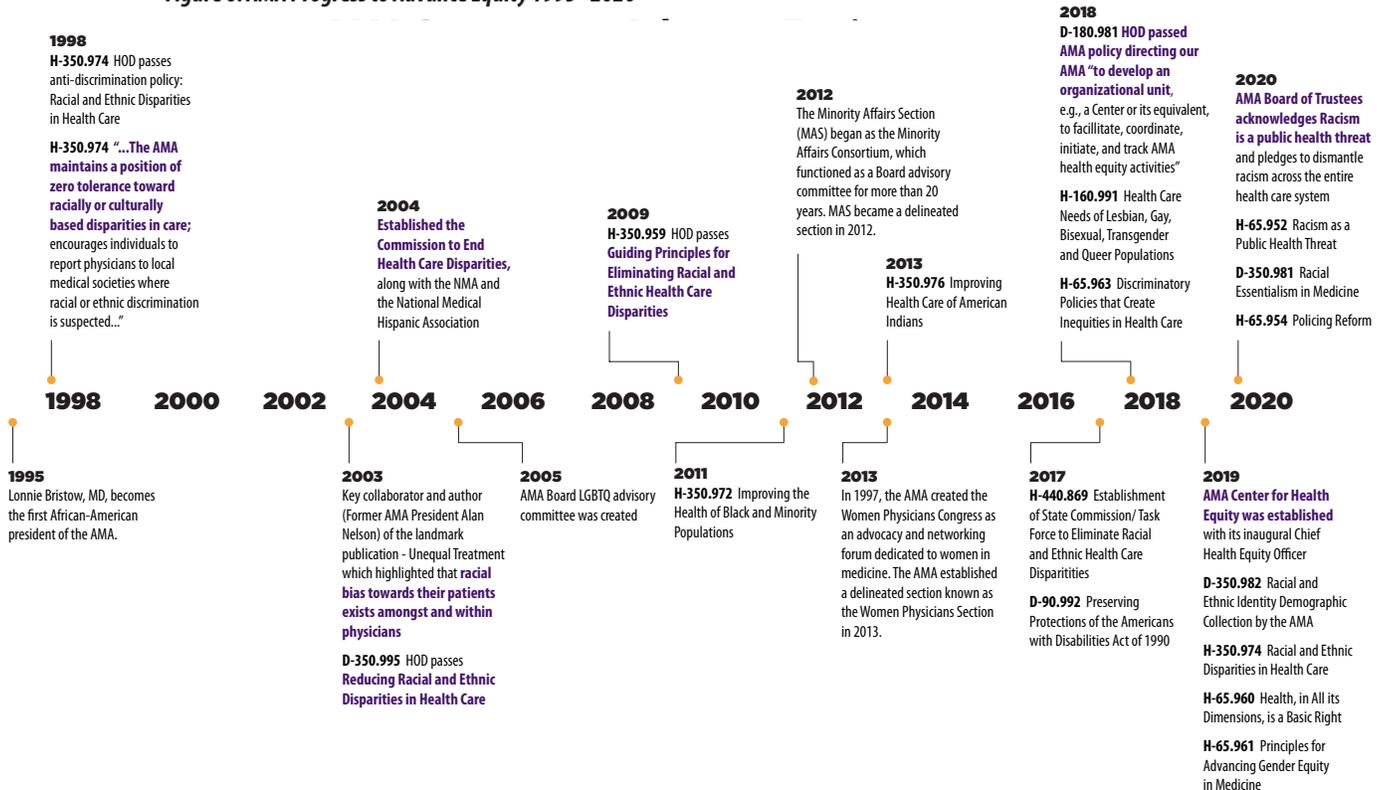
In the past 20 years, the AMA has adopted significant policies focused on equity (see Figure 6). Our AMA efforts in advocacy and policy environments are more gradually and deeply reflecting a commitment to equity. In Appendix #1, we provide a more comprehensive overview of AMA actions taken and policies adopted over the past 25 years, which align with our strategy to advance equity and justice inclusive of race/ethnicity, gender, sexual identity, immigration status, country of origin, language and disability status.

Here are a few highlights of AMA efforts to advance equity throughout history:

- **1965**—Annual HOD: Council on Medical Education (CME) encourages the official requirements for internships be changed to accommodate part time internships, specifically for women with family responsibilities, “to enable women who graduate from medical school and have responsibilities that preclude the possibility of serving full time in an internship program to be eligible for appointment to an internship on a part-time basis...”⁵⁶

- 1971**—Annual HOD: BOT Report O: Physician Manpower and Medical Education Section VII of this report is dedicated to “increasing the production of women physicians.” It offered remedies that may be enacted to encourage women doctors in their careers. “Changes are necessary to increase the number of women physicians. Some of them may already be underway, since the number of women admitted to medical school in the fall of 1970 showed a substantial increase to 11 percent. Among the 17 specific changes deemed as necessary were: (1) increased financial aid to all medical students, including women, (2) continuing emphasis on flexible scheduling during medical school years, (3) flexible scheduling during the internship and residency years and, especially, (4) a social environment more conducive toward the full utilization of talented women in many careers.”⁵⁷ (p. 79)
- 1979**—Annual HOD: Long-Range Planning Report A, investigated women in organized medicine. “The Board of Trustees asked that the Council respond to the charge from the House of Delegates to “...develop plans of action to increase participation of women physicians in the activities of organized medicine” (Substitute Resolution 5, 1-77). The Council reviewed a substantial amount of data and information on the overall subject of women physicians’ role in medicine and spent a half day discussing the subject with Charlotte Kerr, MD, President of the American Medical Women’s Association (AMWA), and Ann Barlow, MD, a member of the AMWA board. This report provided a brief profile of the population of women physicians in the United States at the time and makes some recommendations on what AMA can do to encourage more participation by women physicians.”⁵⁸ (p. 116)

Figure 6: AMA Progress to Advance Equity 1995–2020



- **1979**—October BOT Meeting: Ad Hoc Committee on Women Physicians in Organized Medicine created with “a charge to develop specific recommendations and mechanisms to insure the involvement of women physicians at all levels of the Federation. The final report of the Committee was transmitted to the House of Delegates for its consideration.”⁵⁹ (p. 45)
- **1984**—June BOT Meeting: Women in Medicine Project established to coordinate AMA activities addressing women MDs. “The objectives of this office will be to raise awareness to the need for more fully involving women in organized medicine, to improve women member recruitment and retention, to develop women leaders, and to serve as an information source and liaison to women’s groups.”⁶⁰ (p. 188)
- **2001**—HOD policy (H-140.900) was adopted in Dec. 2001. The policy, in part, stated that among many physician duties that they, “treat the sick and injured with competence and compassion and without prejudice” and “Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.”
- **2003**—the Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care published the seminal report, *Unequal Treatment*, co-edited by Committee Chair and former AMA President Alan R. Nelson, MD,⁶¹ which detailed the ways in which racial bias, prejudice and stereotyping on the part of health care providers affect health outcomes after adjusting for socioeconomic factors lead to unequal care.
- **2004**—the AMA and the NMA, joined soon after by the National Hispanic Medical Association (NHMA), established a Commission to End Health Care Disparities (CEHCD). The 37 member organizations of CEHCD aimed to (1) influence government actions to curtail disparities in health care; (2) engage health professionals and organizations in efforts to eliminate disparities; (3) improve the practice environment to foster effective efforts to eliminate disparities; (4) increase the diversity of the health professional workforce; and (5) promote collaboration between medicine and private industry on strategies to eliminate disparities. An AMA Directive (D-350-991), “Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities” further instructed members of the AMA Federation to work with “the Commission to End Health Care Disparities to develop a national repository of state and specialty society policies, programs and other actions focused on studying, reducing and eliminating racial and ethnic health care disparities,” and for laggard medical societies that were not members to make haste toward membership. (*The CEHD was decommissioned in 2016.*)
- In response to recommendations of an independent panel of experts, convened by the AMA Institute for Ethics, then AMA President Ron Davis, MD, delivered an apology on July 30, 2008, on behalf of our AMA at the NMA’s annual convention:

“...on behalf of the American Medical Association, I unequivocally apologize for our past behavior. We pledge to do everything in our power to right the wrongs that were done by our organization to African-American physicians and their families and their patients.”⁶²

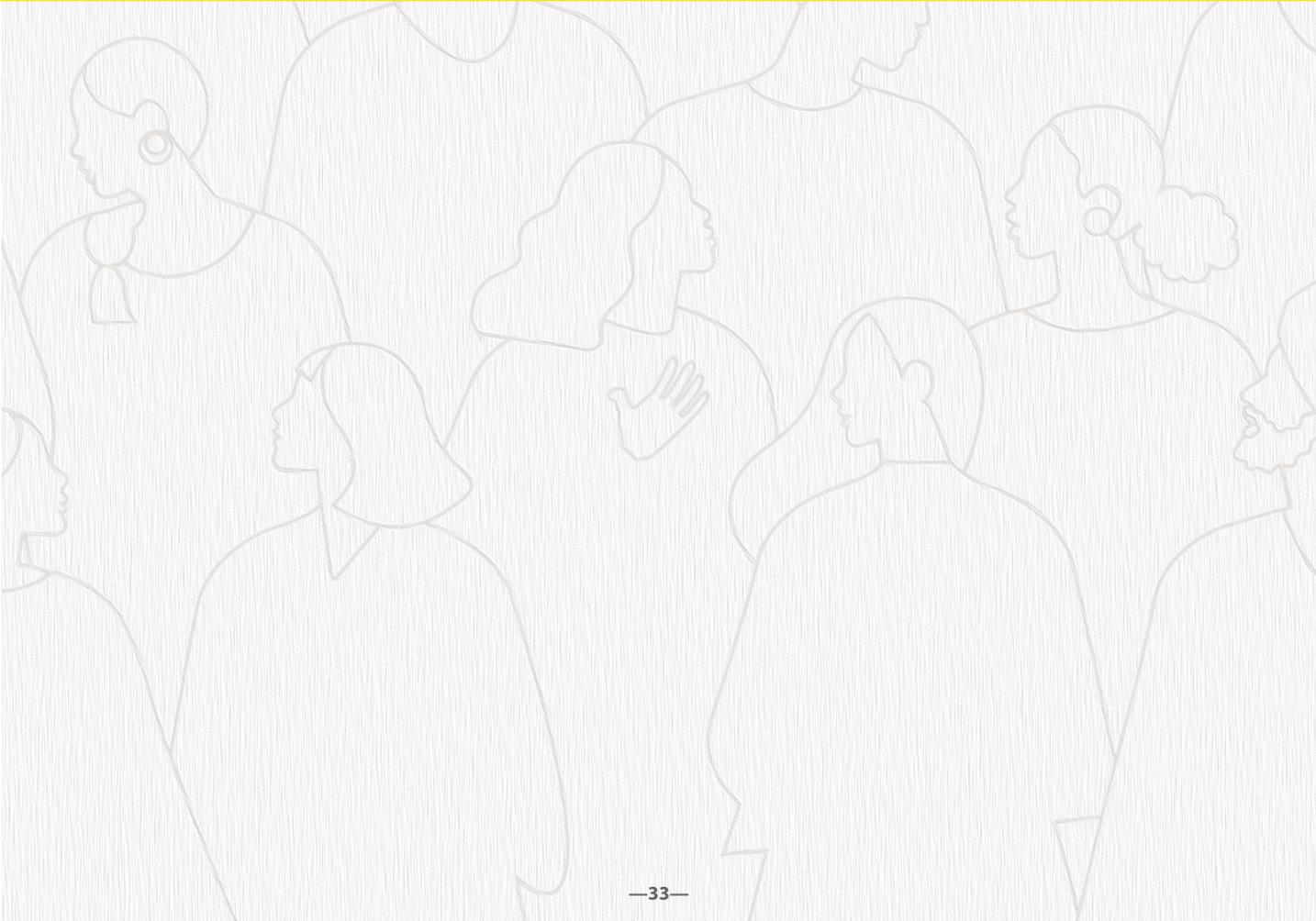
- **2015**—the AMA passed the directive that supports reducing health disparities resulting from unequal treatment of minor and dependent children and their same-sex parents, living in same-sex households.
- **2016**—the AMA recognized the term “women’s health” as inclusive of all health conditions for which there is evidence that women’s risks, presentations and/or responses to treatments are different from those of men, and encourages the incorporation into medical practice, research and training evidence-based information.
- **2017**—the AMA BOT appointed Willarda Edwards, MD, as chair of the task force to produce a report on the state of health equity, after decommissioning the CEHCD in 2016.
- **2019**—our AMA also reaffirmed its commitment to support women in medicine through several policies including D-65.989-Advancing Gender Equity in Medicine and H-65.961- Principles for Advancing Gender Equity in Medicine.
- Reaffirmed in **2019**—the AMA Health Policy document, “Health, In All of Its Dimensions,” is a Basic Right (H-65.960) emphasizes that “(1) enjoyment of the highest attainable standard of health, in all its dimensions, including health care as a basic human right; and (2) that the provision of health care services, as well as, optimizing the social determinants of health as an ethical obligation of a civil society.”
- Early **2020**—in response to COVID-19, which exposed harsh inequities previously and often rendered invisible, and coupled with the unjust public murder of George Floyd by law enforcement, the AMA Board of Trustees issued the following statement:

“The AMA recognizes that racism in its systemic, structural, institutional, and interpersonal forms is an urgent threat to public health, the advancement of health equity, and a barrier to excellence in the delivery of medical care. The AMA opposes all forms of racism. The AMA denounces police brutality and all forms of racially motivated violence. The AMA will actively work to dismantle racist and discriminatory policies and practices across all of health care.”
- November of **2020**—our HOD formally passed key policies that name racism as a public health threat, committing to end racial essentialism in medicine, and confirming race as a social construct, not a biological one, and ridding race as a proxy for biology, ancestry, and genetics.

Note: Please see Appendix #10, for additional qualitative description of key efforts to advance equity.



Section 2
Organizational change work
to move us forward



Establishing the Center for Health Equity



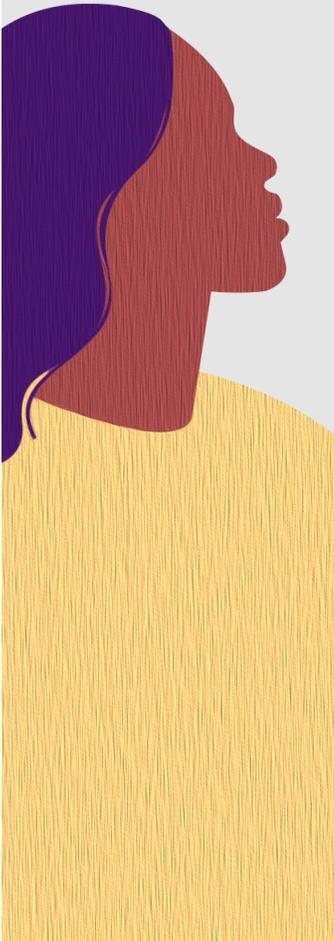
In June 2018, the AMA BOT-appointed The Health Equity Task Force presented its Report 33, A-18, “Plan for Continued Progress Toward Health Equity D-180.981 to the AMA Board of Trustees. A key recommendation in the report directed our AMA “to develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities.” The report and its recommendations were adopted as AMA policy. In April of 2019, the Center for Health Equity was launched, with the hiring of the AMA’s first Chief Health Equity Officer.

The AMA Center for Health Equity is charged with facilitating, strengthening, and amplifying the AMA’s work to eliminate health inequities, which are rooted in historical and contemporary injustices and discrimination.

The vision is a nation where all people live in thriving communities where resources work well, systems are equitable and create no harm, and everyone has the power to achieve optimal health—and all physicians are equipped with the consciousness, tools and resources to confront inequities as well as embed and advance equity within and across all aspects of the health system.

To ensure our work is consistent with equitable practices, the AMA Center for Health Equity has adopted the following values and guiding principles:

- **Inclusion and Power Sharing:** We honor the participation, leadership and expertise arising from many sources, life experiences and identities, to identify health challenges and develop lasting solutions.



- **Accountability:** We recognize that our past, present and future actions have implications, and we are committed to making meaningful amends that support transparency and responsiveness when we cause harm.
- **Openness and Authenticity:** We believe that when we share and communicate our struggles—and challenge dominant and malignant narratives—we can proceed to accept our truths and collectively heal.
- **Social Justice and Reciprocity:** We prioritize equity and believe our futures are bound to the well-being of each other and the land; we believe there is joy and abundance in this work and seek to recognize all contributions.
- **Evidence Informed and Community Driven:** We are rooted in the wisdom and expertise of communities and the shared learnings demonstrated through available evidence, knowledge and stories.

Theories, levers and logic for change



*Our efforts must be motivated by the key question: **How do we ensure our efforts and innovations do not exclude, discriminate, exacerbate inequities, deny care or cause harm?** Our answers must be rooted in confronting the unequal distribution of power and dismantling the systems of power, advantage and oppression that uphold these unjust imbalances. Furthermore, we must recognize the values and myths that undermine advancing and achieving equity and justice.*

To advance equity and justice, we posit that the following theories of change must be embedded in all of our work:

1. Right the injustices of our past

Our AMA recognizes the need to examine, publicly challenge and reckon with our past and present institutional values and actions that produce inequity and harm. We must own our failures as we reckon with our past. Truth, reconciliation, healing and transformation all require organizations to abolish the harmful values and actions that led to our social systems-wide failures.⁶³

2. Counter malignant/dominant narratives pervasive in health

Dominant individual and collective narratives shape our consciousness, meaning and explanations of events. Their effect is to obscure drivers of true power and sites of responsibility. There can be many narratives, but some are more malignant and more glorified than others, because some voices and not others have historically been centered (i.e., more valued) within these narratives.

These malignant narratives are value targets that undermine anti-racism action and progress towards health equity. According to Camara Jones, MD, MPH, PhD, these include the following: a narrow focus on individuals; an historical perspective; the myth of meritocracy; the myth of a zero-sum game; a limited future orientation; the myth of American exceptionalism, and white supremacy.⁶⁴ These value targets contribute to ongoing denial of racism and thereby uphold the systems of oppression. Briefly, we describe two value targets and illustrate how they are upheld and reinforce inequities.

The commonly held narrative of meritocracy is the idea that people are successful purely because of their individual effort, reflected in sayings such as “pull themselves up by their bootstraps” or “people just need to make better choices.” The narrative is powerful and harmful because it connects to these values, which are important and legitimate. But it also ignores the inequitably distributed social, structural and political resources that influence health and limit individual-level control or effort.

Medical education has largely been based on such flawed meritocratic ideals, and it will take intentional focus and effort to recognize, review and revise this deeply flawed interpretation, which ignores, or purposively obscures, the underlying root causes of causes (of health and of other metrics of success) that are socio-structural in nature and, often, rely on discredited and racist ideas about biological differences between racial groups.

Holding fast to dominant narratives keeps one from seeing other significant elements that contribute to success and wellness, such as the material, resource or opportunistic advantage or support one may have received from others that lend directly to the conditions of one's life and lifestyle, and also the social conditions under which one has lived. They catapult one into achievement or, conversely, the conditions that have inhibited one's flourishing.

The narratives shape consciousness (individual and collective in scope), meaning and explanations of events. They divide populations who possess common concerns, enforce social compliance with ideals and its respective power structure, and ensures that opposing visions of society's future do not become reality.

There are powerful narratives about “race” that exist within American society, particularly as represented in being “color blind” in ways that render invisible the ongoing burden of structural racism across a wide range of policies and systems, including within health care.⁶⁵ Yet, as Camara Jones, MD, MPH, PhD, reminds us, racism advantages groups provided with unfair/unjust privileges through structuring opportunity and assigning value based on socially defined categories of race.

A critical component of doing health equity work at the institutional level involves naming, disrupting, dismantling and reimagining our collective narratives that hinder the nation's ability to fully reach optimal health for all.

3. Center and integrate the voices and ideas of those most historically marginalized

“We have to be visible. We should not be ashamed of who we are. We have to show the world that we’re numerous.”

—Sylvia Rivera, 1951–2002, transgender rights activist and a founding member of the Gay Liberation Front

We recognize dominant/malignant narratives have disenfranchised the voices, experiences, idea and expertise of those who have been most historically marginalized. These voices are often those most directly impacted by inequity (*see Appendix #12*) and are also the most frequently excluded from mainstream conversations and decision-making. We are building on our work by explicitly and systematically valuing and centering marginalized voices and ideas to ensure we promote and honor the inherent power, autonomy, storytelling, community narrative and leadership of those most affected by health injustice. This requires that we seek out, value and engage their expertise and knowledge and uphold their values in any given initiative, policy and advocacy effort, centering them as thought leaders in the movement towards health equity and justice. We must adopt collaborative and participatory approaches and ensure that we use the theories (intersectionality, critical race theory*, etc.), tools and approaches that allow us to consistently identify, elevate and work with marginalized groups in any spaces.

4. Adopt anti-racist and intersectional (Race AND _) approaches.

“When we identify where our privilege intersects with somebody else’s oppression, we’ll find our opportunities to make real change.”

—Ijeoma Oluo, writer, speaker and internet yeller, *So You Want to Talk About Race*⁶⁶

Our work must recognize how systems of power intersect to create and reinforce inequities, particularly based on race. We lead with race because history and the evidence compel us to do so. Racial inequities, representing some of the largest gaps amongst populations in this country (*see Appendix #11 for examples*), exist and persist in every system examined across the country: Health care, education, criminal justice, employment and housing. Conversations on race and racism also tend to be some of the most difficult for people in this country to participate in for numerous reasons, including a lack of knowledge or shared analysis of its historical and current underpinnings, as well as outright resistance and denial that race or racism exist.

Engaging in anti-racist work requires both a personal commitment to an internal process of working through the trappings of white supremacy, and dominant thinking. It also entails institutional-wide commitment to processes and producing policies that acknowledge and confront racism as a disease and public health threat. We are owning the responsibility to end racism across our institution; being advocates of social justice, using our AMA institutional voice to speak during moments of injustices, and recognize humility, appreciating the decades of work in pursuit of justice already done by Black,

* Critical race theory born out of both legal studies and education scholarship is a framework that centers experiential knowledge, challenges dominant ideology, and mobilizes interdisciplinary action and research in order to uncover inequalities related to race and racism and other intersectional identities and/or experiences.

Indigenous, Latinx and people of color; making public statements that are further reinforced by external-facing actions; and committing to rooting out racism and white supremacy in our workplace.

We recognize that across other dimensions of marginalization (including gender, gender identity, sexual orientation, disability, age, class/socioeconomic status, citizenship status and language), structural racism remains a significant injustice. It is critical to address all areas of marginalization and inequity due to sexism, class oppression, homophobia, xenophobia and ableism. This recognition calls for us to apply an intersectional approach, a “race AND _” approach, in which we continually acknowledge that these overlapping identities create unique modes of advantage and oppression.

AMA's work is evolving and deepening its commitment to establish a new legacy, grounded in core values of equity, anti-racism and social justice. As our institution deepens its pledge to strive toward advancing racial and social justice within health care, it will be better equipped to transform systems and institutions impacting all marginalized groups.

5. Embrace public health frameworks of health and act upstream

Systems of power and oppression, structural and social drivers of health inequities shape a person's and community's capacity to make healthy choices. Downstream opportunities provided by the health care system and individual-level factors are estimated to only contribute 20 percent to an individual's overall health and well-being, while upstream opportunities of public health and its structural and social drivers account for 80 percent of impact on health outcomes.

In contrast, historically there has been a dramatic difference in investment with downstream solutions (individual/treatment/health care) receiving substantially more resources compared to upstream solutions (community/prevention-public health). If we are to impact health and well-being significantly, we must strategically assign greater value to the root causes, political, structural and social realities that produce inequity. Increasingly, this is described as the “upstreamist” approach in health care. To “move upstream”^{*} means to continuously seek to address the root causes of health inequities both within traditional clinical settings, and within the larger community's health institutions occupy, and transform the structures that generate health inequity. To “move upstream” means to:

- a. Act against the structural determinants or systemic generators of health inequity
- b. Improve community/neighborhood-level social determinants of health; and
- c. Support and meet individual and family social needs, as well community needs and networks

6. Implement an “inside-outside” strategy to organizational transformation

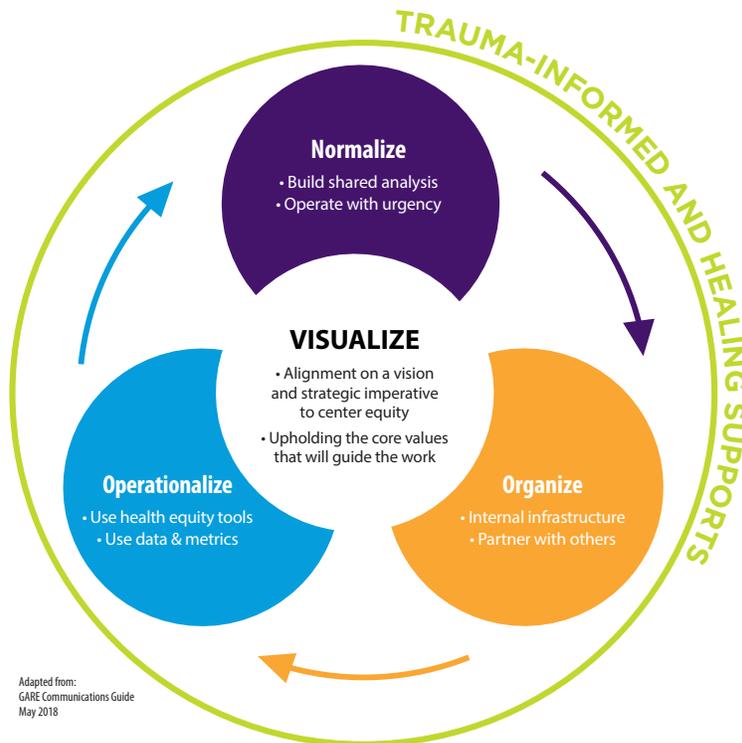
Our organizational commitment to advance equity and justice must exist at the innermost workings of the AMA enterprise. We must “get our house in order” and direct significant focus on embedding equity within the management team (inside) and amongst membership

^{*} Adapted from HealthBegins Upstream Communications Toolkit. May 2019.

(inside/outside) if we intend to influence and contribute to advance equity and justice in the external environments of medicine (outside) and innovation. The management team works on behalf of membership under the direction of the BOT, and primarily is responsible for executing and operationalizing policies passed by AMA's House of Delegates. Therefore, knowledge and skill building to support staff in the management team to challenge their own mental models that may exacerbate inequity is critical, as is setting equity-explicit goals and performance metrics for all staff within all business units (BUs) of the organization, especially in the areas of organizational commitment and leadership, workforce equity and competencies, engagement and partnerships, internal and external communications and marketing, sourcing and contracting, data collection and metrics, publishing, advocacy and innovation. Accountability rests with all levels of leadership.

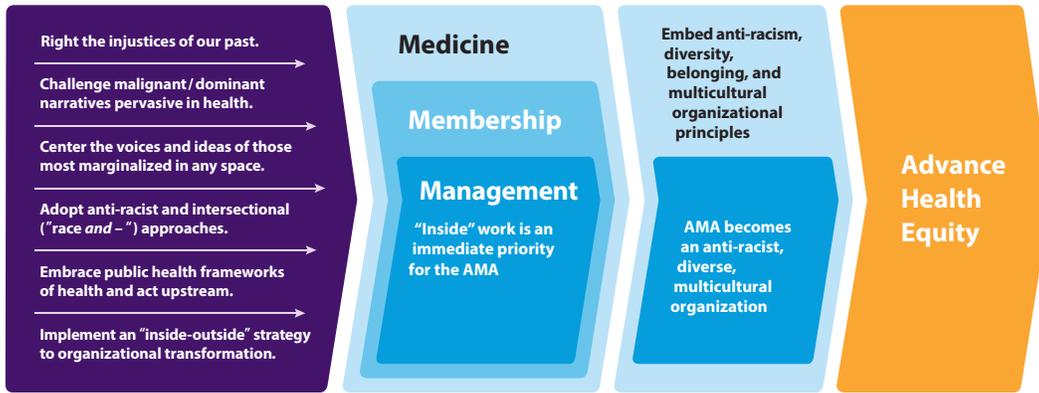
The management team's organizational change work is informed by the GARE (Government Alliance on Race and Equity) and Race Forward's transformation model: Visualize, Normalize, Organize and Operationalize, in which the work of embedding equity is a cyclical process to inform and change organizational culture, policy and practice (see Figure 7). We have expanded upon this work to ensure trauma-informed systems and supports in all aspects. Trauma-informed systems, which include psychosocial support and mindfulness resources, work to mitigate potential conflict, trauma (or re-trauma) and harm that occur as a result of this transformational work. Trauma may be related to racial trauma, historical trauma, current events related to this work, and other forms of trauma. We must be intentional to build institutional structures that automatically consider and activate trauma-informed responses, resources, resilience and healing, to more effectively achieve our transformational goals.

Figure 7. Visualize, Normalize, Operationalize Transformational Model



Explicit to this work is educating, empowering and mobilizing our AMA membership in advancing equity and justice. Understanding that the AMA has long been a powerful voice and leader across the broad field of medicine, this recognizes the potential that the AMA's own commitment to equity and justice must work to influence and transform medicine at the sector level.

Figure 8. Theories of Change Needed to Center Equity



Levers for change



The following levers are critical to operationalizing our long-term goal of advancing health equity. Each of these levers offers opportunities for strategies and meaningful deliverables that drive our work.

It is our understanding that each of these levers contributes to successful outcomes. These levers are not created or used in a vacuum. Instead, they all contribute to scaling, implementing, and reinforcing our approaches. The levers must reflect the “what” and “who” of the intended change we aim to produce. This will be accomplished through ongoing assessments and strategy formulation before creating or revising any of the levers.

Relationships, partnerships and network: The relationships, partnerships and network levers aim to create intentional space, convening and/or providing supports to bring about sustainable change. We aim to build and nurture longstanding, authentic and transformative relationships. This takes time, space and reciprocity. Through this lever, we intend to expand and amplify our relationships with those groups that are most marginalized to advance our strategic goals. In so doing, we embrace cohort learning through communities of practice that focus on sharing innovative and promising best practices in order to create new knowledge that will advance medicine, public health and professional practice.

Data use, research and publications: The research, data use and publications lever aims to conduct research that moves beyond description to action; moving from the “problem space” to the “solution space.”⁶⁷ Our research efforts must be built on collaboration and ongoing partnership with communities often marginalized from traditional research, building bridges between medicine and public health. Our methods will be informed by social epidemiology and critical race theory, recognizing the deep-rooted structural and social drivers of health.

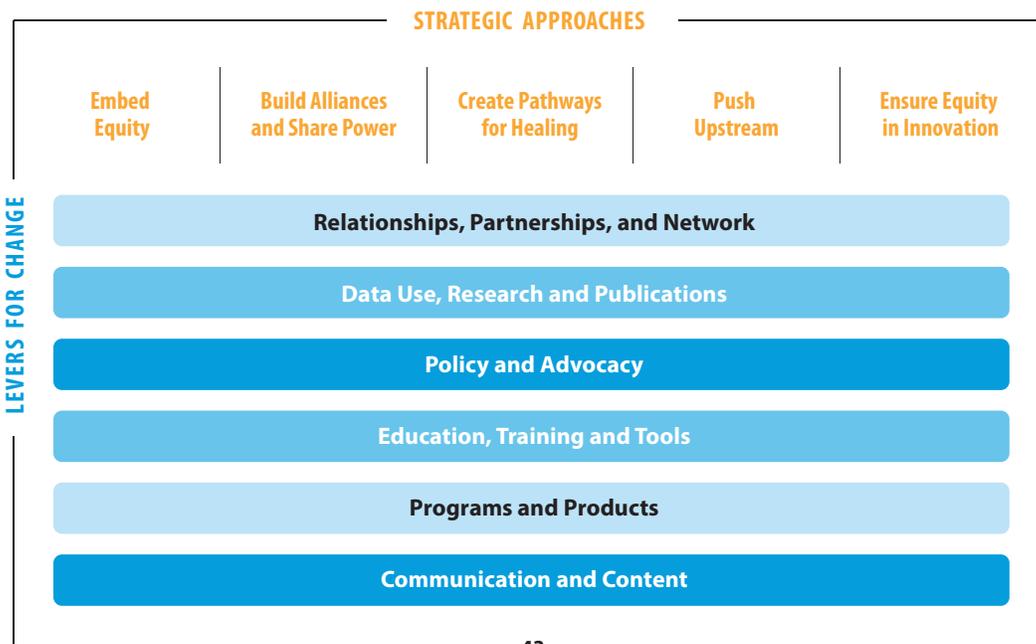
Policy and advocacy: We recognize that health and health care are political and driven by economic considerations. Government and agencies can govern in the interests of promoting health equity and ultimately the well-being of their constituents and communities. Government has the potential to organize the efforts of every sector in society to promote health and health equity in all activities. It is our role to advocate that health equity be considered in all policies and to advocate alongside others on behalf of these efforts.

Education, training and tools: The education, training and tools lever capitalizes on AMA's expertise in creating and delivering effective training for medical students, fellows, physicians, innovators and health systems. We will leverage our existing relationships in the medical education community and our internal expertise and resources to advance equity. For example, AMA's Ed Hub™ is a platform resource that supports medical education and training. This platform has the power to influence the extent to which health equity and related concepts are embedded in medical education and ongoing training. In addition to external training, we also recognize the importance of internal training and education of staff on health equity and anti-racism.

Programs and products: The programs and products lever aims to deliver timely and needed programming that benefits medical students, residents, physicians and the communities they serve. Evidence-based programming is driven by needs assessments, strategic partnerships and proof of concept research to leverage our resources.

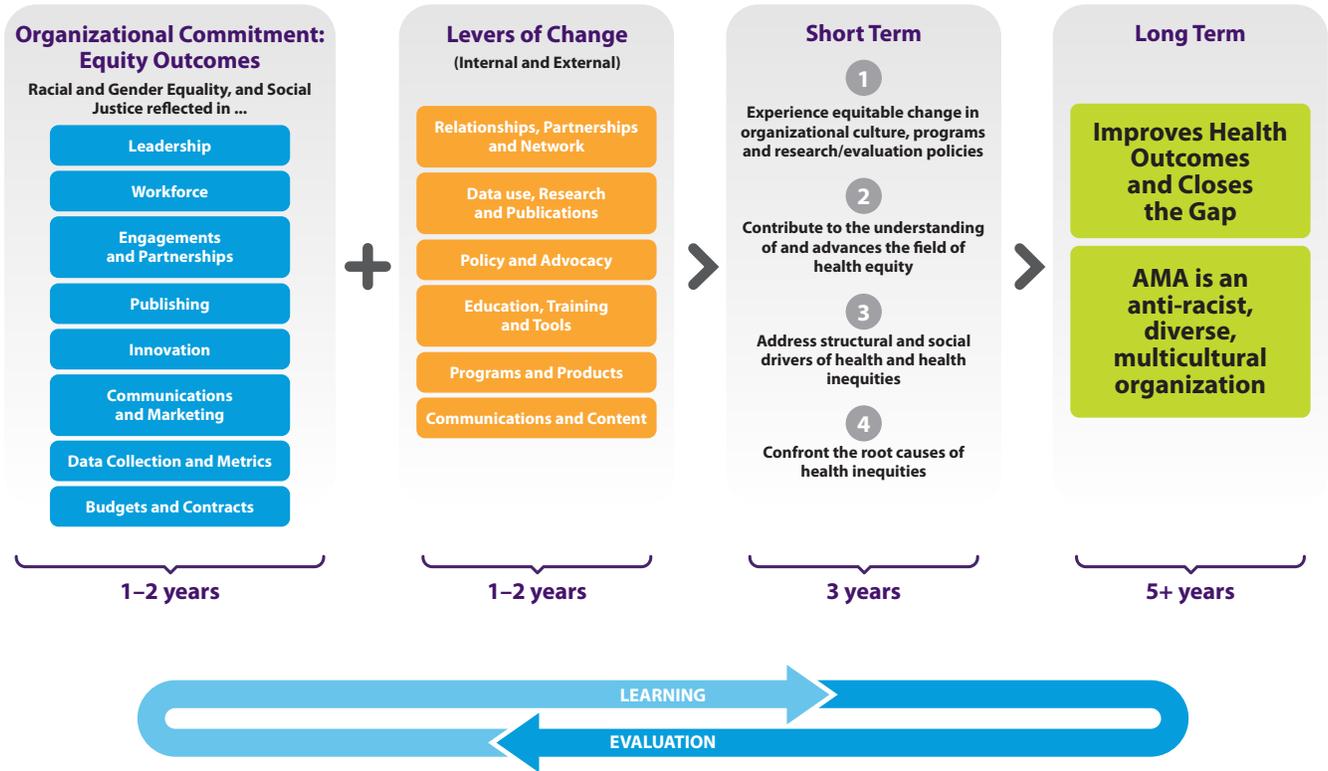
Communication and marketing: The communication and marketing lever is one of the AMA's most valuable tools, if aimed at changing the narrative and actions around health equity, nationally. Amongst the many strengths of the AMA are its reach and influence. Our communication plan is critical because it guides us to: Develop and distinguish the AMA's equity narrative in the national dialogue; identify the appropriate audiences and proper platforms for amplification; provide relevant tools and content that informs, educates and empowers; implement best practices for expanding visibility and the dialogue centering health equity; and sustain engagement and spark action.

Figure 9. Levers for Change



Our logic model for change

Figure 10. AMA's Health Equity Logic Model



The logic model (see Figure 10) begins with clear organizational commitments to equity throughout the enterprise, from leadership to data collection, budgets and contracts, to uncover any source or driver of inequity. We use internal and external levers for change, including research and data use, policy and advocacy, education and communications, to accelerate and amplify our efforts. Our short-term impacts will be seen in the reflection of equity principles in management, AMA membership, throughout the field of medicine, and in our capacity to consistently name and confront the root causes of health inequities.

The logic model summarizes the work at a strategic level and allows for the AMA enterprise to operationalize strategic pathways to achieving equity. If equity is effectively embedded, it will be present as an organizational commitment and reflected in all its operations and structures.

Five strategic approaches to advance equity and justice



Our strategies are grounded in the expertise of the AMA Center for Health Equity team, our present and past leadership and strong scientific evidence. Specific key actions are listed in Section 3.

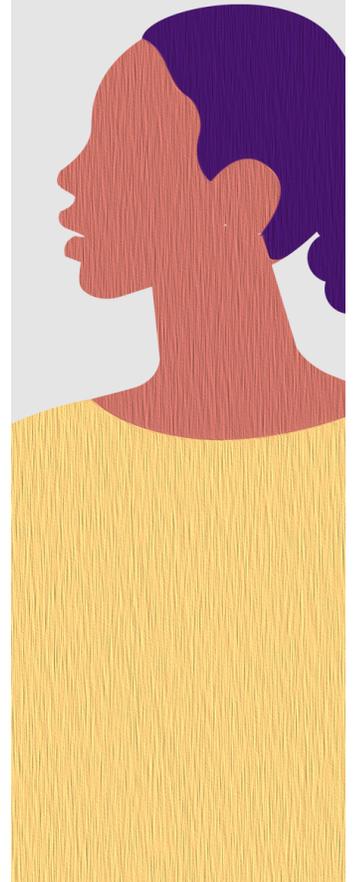
1. Embed racial and social justice throughout the AMA enterprise culture, systems, policies, and practices

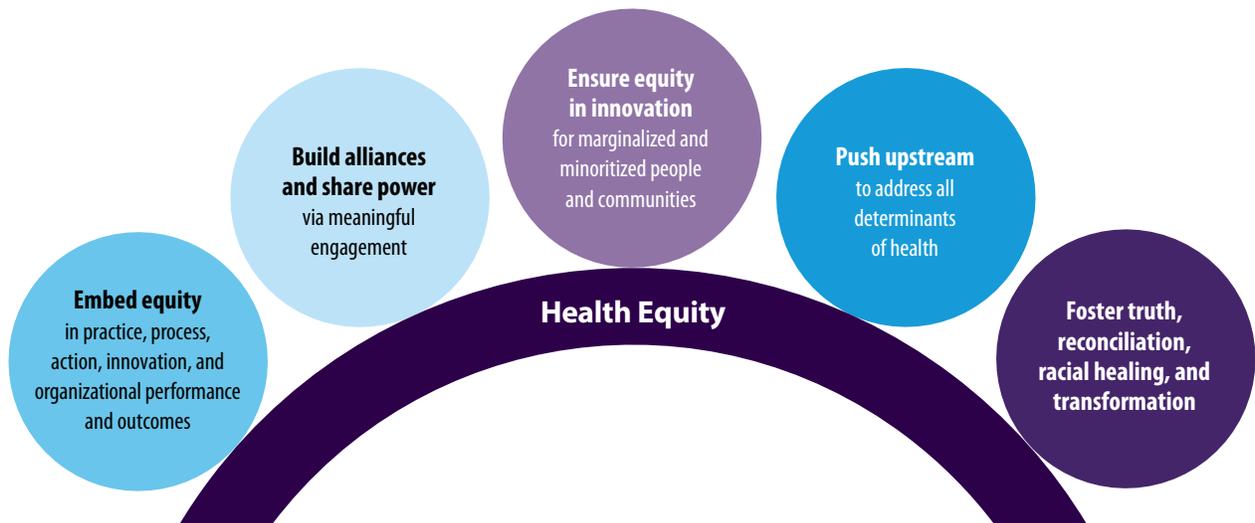
“We will be really misled if we think we can change society without changing ourselves.”

—Alice Walker, internationally renowned author, poet and activist⁶⁸

Embedding racial and social justice into culture, systems, policies, and practices does not happen without intentionality and purpose. The AMA's management team (and its 1,100+ person total staff) that implements and executes on policies passed by our 600-plus House of Delegates must be equipped with the knowledge, skills, tools and culture to challenge their own assumptions and mental models that may serve to exacerbate inequities, rather than eliminate them. Embedding equity and justice into all of AMA's business unit workflows, goals, objectives and performance measures allows us to support transformation by reimagining medical education, enhancing medicine's role in public health through its policymaking and supporting the construction of a more just health care system.

The AMA management team began organizing internal efforts for change by establishing Diversity, Inclusion and Equity Workgroups in 2018; merging into one group in 2019. (See Section 3 for 2019 key accomplishments). Over the past two years, there has been tremendous progress





with training activities started (e.g., Racial Equity Institute 2-day workshop), building of an internal accountability infrastructure to ensure we do what set out to do, creating and increasing the spaces for truth telling and psychological safety supports. (*Other accomplishments are listed in Section 3.*)

To support our AMA membership and the health care community, tools for how to embed racial and social justice and trainings modules on ways to advance equity and justice will be developed and disseminated.

To embed racial and social justice throughout the AMA, we commit to:

- **Build the AMA's capacity to understand and operationalize anti-racism and equity strategies via training and tool development**
 - Normalize conversations and trainings around racism and other forms of oppression as primary drivers of health inequities
 - Organize educational opportunities and events for internal collaboration and external engagement around equity
 - Operationalize equity work across AMA business units by proliferating tools and resources
 - Fortify anti-racism and equity programming and advocacy/policy strategy with the Federation (154 physician specialty associations and 54-plus local/state medical societies).
- **Ensure equitable structures and processes and accountability with prioritization on the AMA's workforce, contracts/sourcing and communications**
- **Integrate trauma—informed lens and approaches**
 - Build an internal culture that values spaces for psychological safety and truth-telling
- **Assess organizational change (culture, policy, process) over time**
 - Share the AMA's internal organizational change efforts

2. Build alliances and share power with historically marginalized minoritized physicians and other stakeholders

“If you have come here to help me you are wasting your time, but if you have come because your liberation is bound up with mine, then let us work together.”

—Lilla Watson and Aboriginal Rights Group*

Advancing health equity requires sharing power through effective partnerships and alliances with those who have experienced marginalization, exploitation, expropriation and injustice across generations.

Our AMA has a powerful role as a leader in organized medicine. Our ability to share power also recognizes that the AMA has an active role to play in leading change while also recognizing there are other voices, entities and communities that must be centered that have been previously excluded. The sustainability of the AMA's external initiatives is critically influenced by our organizational credibility and our ability to authentically attract and foster partnerships with long-existing health equity leaders and influencers. The AMA will convene local groups and stakeholders enhancing how medicine, health care, and public health collaborate to ensure that the work is strengthened and translates into system-level improvements. We do this foremost by carrying out the objective of our HOD policy, namely harkening back to the edict and directive of D-350-991, “Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities,” which calls for members of the AMA Federation (a collective of 154 physician specialty societies and 54-plus local and state medical societies) to work with “the Commission to End Health Care Disparities to develop a national repository of state and specialty society policies, programs and other actions focused on studying, reducing and eliminating racial and ethnic health care disparities.” We have yet to see this initiative through to fruition—now is the time.

To build alliances and share power, we commit to:

- **Develop structures and processes to consistently center the experiences and ideas of historically marginalized (women, LGBTQ+, people with disabilities, International Medical Graduates) and minoritized (Black, Indigenous, Latinx, Asian) physicians**
- **Establish a national collaborative of multidisciplinary, multisectoral equity experts in health care and public health to collectively advocate for justice in health**
— Engage in collective advocacy opportunities with other physician groups with anti-racism and equity interests.

* Quote by Lilla Watson and Aboriginal rights groups. Lilla Watson is a Murri (Indigenous Australian) visual artist, activist and academic working to address women's issues and advance Aboriginal rights. Quote frequently attributed to 1985 United Nations Decade for Women speech by Lilla Watson.

3. Push upstream to address all determinants of health and the root causes of health inequities

“There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they’re falling in.”

—Desmond Tutu, Nobel Peace Prize laureate,
South African human rights and justice leader and advocate*

Much of medicine still looks for cultural, behavioral or even genetic explanations to understand and justify the gaps in life expectancy, diabetes-related mortality and potential years of life lost amongst populations when analyzing data. It will take intentional focus to recognize and revise this deeply flawed interpretation which ignores, or purposively obscures, the underlying socio-structural root causes of health, in favor of discredited and racist ideas about biological differences between racial groups.

The upstream movement seeks to effectively integrate clinical and social care as well as medicine and public health. This movement recognizes the moral and business imperative for physicians and trainees to be educated beyond the traditional basic and clinical sciences of medicine and to be inclusive of public health, structural competency, anti-racism and the social sciences.

To push upstream, we commit to:

- **Strengthen physicians’ understanding of public health and structural/social drivers of health and inequities**
 - Expand medical school and physician education to include equity, anti-racism, structural competency, public health and social sciences, critical race theory and historical basis of disease
- **Empower physicians and health systems to dismantle structural racism and intersecting systems of oppression**
 - Advance a new paradigm for health care as a key driver of social and racial justice, by linking provider and health care system advocacy to other sectors such as public health
 - Develop tools and networks for health care institutions and systems to embed equity throughout their institutions, with a focus on quality and safety.
- **Equip physicians and health systems to improve services, technology, partnerships and payment models that advance public health and health equity**
 - Accelerate and support the formation of cross-sector coordination, use of technology, adoption of national equity standards, and payment models that support integrated social needs and community-based social determinants of health approaches.

* Quote by Bishop Desmond Tutu, 1931-present. Human rights and anti-apartheid activist and Nobel Peace Prize winner in 1984.

4. Ensure equitable structures and opportunities in innovation

The key is that all this takes time and intention, which runs against the rush to innovate that pervades the ethos of tech marketing campaigns. But, if we are not simply “users” but people committed to building a more just society, it is vital that we demand a slower and more socially conscious innovation.

—Ruha Benjamin, professor and author, rooted in perspectives from South Central Los Angeles; Conway, South Carolina; Majuro, South Pacific and Swaziland, South Africa, *Race After Technology*⁶⁹

The AMA is committed to ensuring equitable health innovation for historically marginalized and minoritized people and communities. With deep resources committed to innovation in large health care and health-focused tech companies and billions of dollars of annual investment in health startups, including \$10.7B of venture capital in 2019 alone,⁷⁰ we believe the health innovation sector has incredible potential to advance health equity. Current models of health innovation problem definition, evidence development, solution design and market selection do not incorporate an equity lens, risking exacerbation of health, racial and social injustices. The AMA Center for Health Equity is collaborating with stakeholders across the AMA and within our innovation-focused subsidiary, Health2047, to embed racial justice and health equity into our existing innovation strategies, processes, products and policies—including our digital health, telemedicine, AI, precision medicine, data and interoperability initiatives.

Our vision is that the U.S. health innovation sector: (1) prioritizes resource allocation to launch and scale solutions that are meaningfully advancing health, racial and social justice, and (2) the race, ethnicity, and sexual orientation and gender identity of health care investors and innovators mirrors that of our nation, in both proportional representation and allocation of resources. While social benefit is often seen as a philanthropic effort, data supports that health equity-focused investment strategies could also result in positive financial returns.⁷¹ There is also a business case for increasing diversity in our health care innovator community.^{72,73} The AMA has the opportunity to amplify business cases for the health care industry to leverage innovation to advance equity, and to help create conditions that support these opportunities by using our unique assets and resources.

To advance equitable opportunities in innovation, we commit to:

- **Embed equity within existing AMA health care innovation efforts**
 - Engage marginalized patients in the design and validation of health innovation solutions
- **Equip the health care innovation sector to advance equity**
 - Create and publish foundational content on equitable innovation principles, processes and practices
 - Develop an approach and collaboration model for health equity and innovation data collection and integration
- **Center and amplify historically marginalized and minoritized health care investors and innovators**
 - Invest in research-driven opportunities to support marginalized innovators, investors and patients

- **Engage in cross-sector collaboration and advocacy efforts**
 - Establish a collaborative of physician groups representing marginalized and minoritized physicians and communities as advisors to the AMA's health innovation activities

5. Foster truth, racial healing, reconciliation and transformation for the AMA's past

“My story may be rooted in trauma but it is not my only story.”

—Elaine Alec, author, political advisor, women's advocate, spiritual thought leader and teacher, and direct descendant of hereditary chiefs, Pelkamulaxw and Soorimpt, *Calling My Spirit Back*⁷⁴

“Many people may rightly say, “I had nothing to do with how this all started. I have nothing to do with the sins of the past. My ancestors never attacked indigenous people, never owned slaves.” And, yes. Not one of us was here when this house was built. Our immediate ancestors may have had nothing to do with it, but here we are, the current occupants of a property with stress cracks and bowed walls and fissures built into the foundation. We are the heirs to whatever is right or wrong with it. We did not erect the uneven pillars or joists, but they are ours to deal with now.”

— Isabel Wilkerson, journalist, author, native of Washington, D.C., and daughter of the Great Migration, *Caste: The Origins of our Discontents*⁷⁵

Recognizing and rectifying historical injustices is essential for advancing health equity. According to the National Collaborative for Health Equity, Truth, Racial Healing, and Transformation (TRHT),⁷⁶ TRHT is a framework to better understand how the belief of the hierarchy of human value is embedded in our culture, systems and structures (laws and policies). At the AMA and amongst other medical societies, physician associations and health care institutions, the need “for asserting the truth, documenting the facts and creating safe spaces for related healing and trust building remains.” The AMA Center for Health Equity would assert this entire strategic plan aligns with values, intentions and desired impacts of THRT.

We, the AMA, cannot do this alone. TRHT is foundationally designed to spark and ensure cross-sectoral and collaborative energy and work. Fortunately, in accordance with our House of Delegates policies that outline collaborative pathways with organizations, the next three years and beyond will be spent intentionally creating spaces and plans for truth, reconciliation and healing at the institutional level. This work will be essential for reaching our aspirations not only for equity but for justice, especially for those who currently do not receive it (known as applicative justice, according to philosopher Naomi Zack) and correcting injustice by applying justice experienced by those with privilege and giving power to those who do not.⁷⁷

Justice, healing and restoration will necessitate always centering and integrating Black, Latinx, Indigenous and other historically marginalized voices and ideas in this strategic

approach. This building of narrative power,⁷⁸ a presence that forces changes in decision making and the status quo in value added ways. Answering critical questions such as, “How can we disrupt the narratives that perpetuate racism and white privilege? What counternarratives and stories need to be told to shift cultural consciousness? What kinds of alliances, infrastructure and institutions are necessary?” provides meaningful direction to learn different truths, expose what has been made invisible, and add a sense of humanity to the existing scientific evidence base.

Ultimately, healing does not come without the repair of harm. As an example and explained by Bram Wispelwey and Michelle Morse, Sandy Darity’s⁷⁹ framework for reparations includes:

Acknowledgement: “involves recognition and admission of the wrong by the perpetrators or beneficiaries of the injustice”

Redress: “a direct solution to monitor and end health inequities and restitution for past and present injustices,” and

Closure: the institution and the people and communities harmed agree that the institutional debt “is paid,” leaving a new and equitable structure and system in place that no longer causes trauma or harms.

Restorative justice is another framework, valuable approach in health care, as it prioritizes the personal connection and humanistic values that attracted most physicians to the field, it embraces community power and active accountability and preserves the safety and dignity of all. Also, a collaborative decision-making frame, restorative justice includes: (a) acceptance and acknowledgement of responsibility for harmful behavior, (b) repairing of the harm caused to individuals and the community, and (c) rebuilding of trust by showing understanding of the harm, addressing personal issues, and building positive social connections.

To acknowledge our past and ensure healing, we commit to:

- **Amplify and integrate often “invisible-ized” narratives of historically marginalized physicians and patients in all that we do**
- **Quantify impacts of AMA’s policy and process decisions that excluded, discriminated and harmed**
 - Launch a multi-year restorative justice initiative to further enhance the AMA’s transformation efforts
- **Repair and cultivate a healing journey for those who have been harmed**

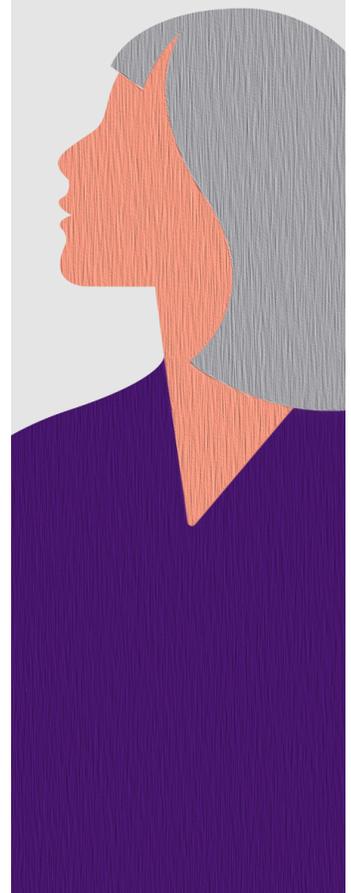
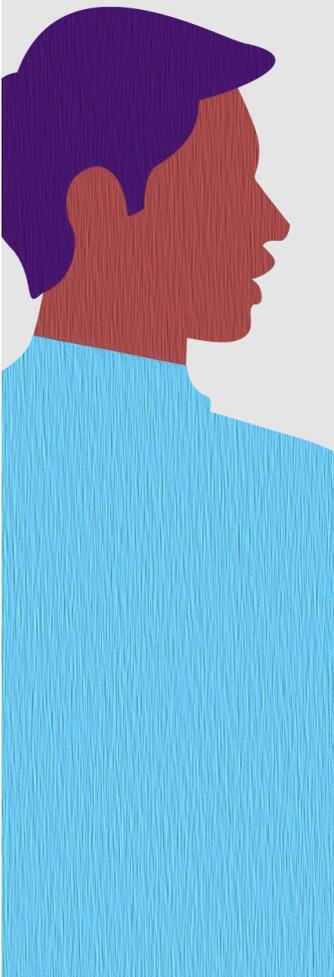
Measuring our effectiveness—and ensuring accountability



Assuring accountability and key performance indicators

We are committed to accountability and transparency and in order to do so, we have put in place the following accountability actions and measures to inform our work:

1. Guided by the Results-Based Accountability (RBA)⁸⁰ Framework, we will implement right-sized internal and external performance dashboards to apply a racial equity lens and track our progress using key performance indicators for each of our Five Strategic Approaches. The three performance measures for each of our Strategic Approaches are:
 - How much did we do? (Quantity, number of events and/or activities)
 - How well did we do it? (Quality, percentage of activity that was of high quality, percentage of common measures of appropriate/high quality)
 - What are our measures of success? (How do we know if we met our target for each approach?)
2. In accordance with Policy D-180.981, the AMA Center for Health Equity will prepare a report to the BOT as part of the annual report to the House of Delegates regarding AMA's health equity activities and achievements.
3. The AMA also has implemented Health Equity performance metrics across the organizational performance management system at the BU level as well as the individual staff level.
4. The AMA Center for Health Equity commits to creating an annual external report.



Embedding learning to maximize impact

We will integrate learning as part of our strategic plan to ensure that we are continually using our resources and opportunities to have the greatest impact. We will question:

- How can we work more effectively?
- How can we ensure that our experiences last week, last year and over the last decade inform our work so we can create greater impact going forward?
- How can our strategy be increasingly relevant, values-driven and mission-driven?
- How do we ensure sustainability of our efforts (or at least know if they are sustainable)? How will we know if our efforts are no longer needed?
- How do we use our resources to foster and sustain equitable partnerships?
- How has the process informed the outcome?
- How do we center healing and reciprocity?
- In what ways is the AMA catalyzing health equity?
 - What are the strengths and opportunities that AMA leverages to advance health equity?
 - What are the challenges and areas of growth that the AMA must resource to advance health equity?

Strategic learning, as a practice, requires ongoing reflection, assumption checking and iteration to maximize impact and hold ourselves accountable to our measures of success. As we embark on this journey, our work will focus on these learning questions. We will also ensure that we have evaluative data to guide our decision-making moving forward and drive the direction of our work as we look to continue to strengthen our strategy and proactively design the next iteration of our work. Using structured-learning activities supports collaborative learning and our ability to adapt to the constantly changing landscape.

Measuring our impact to advance health equity

Advancing health equity wholly requires comprehensive evaluation approaches and tools including but not limited to the following domains:

- Health Equity (i.e., as a general metric in medicine, in advocacy, in policy)
- Partnerships and sharing power (i.e., trust, reciprocity, power sharing)
- Diversity, equity and inclusion (i.e., AMA workforce, membership and medicine)
- Cultural shift (i.e., attitudes, behaviors and policies)
- Truth, racial healing, reconciliation and transformation (i.e., qualitative interviews to understand extent of past harm and progress towards healing, reconciliation and transformation across different sectors of health care and public health)
- Impact (i.e., mission, audience reach, membership and brand)

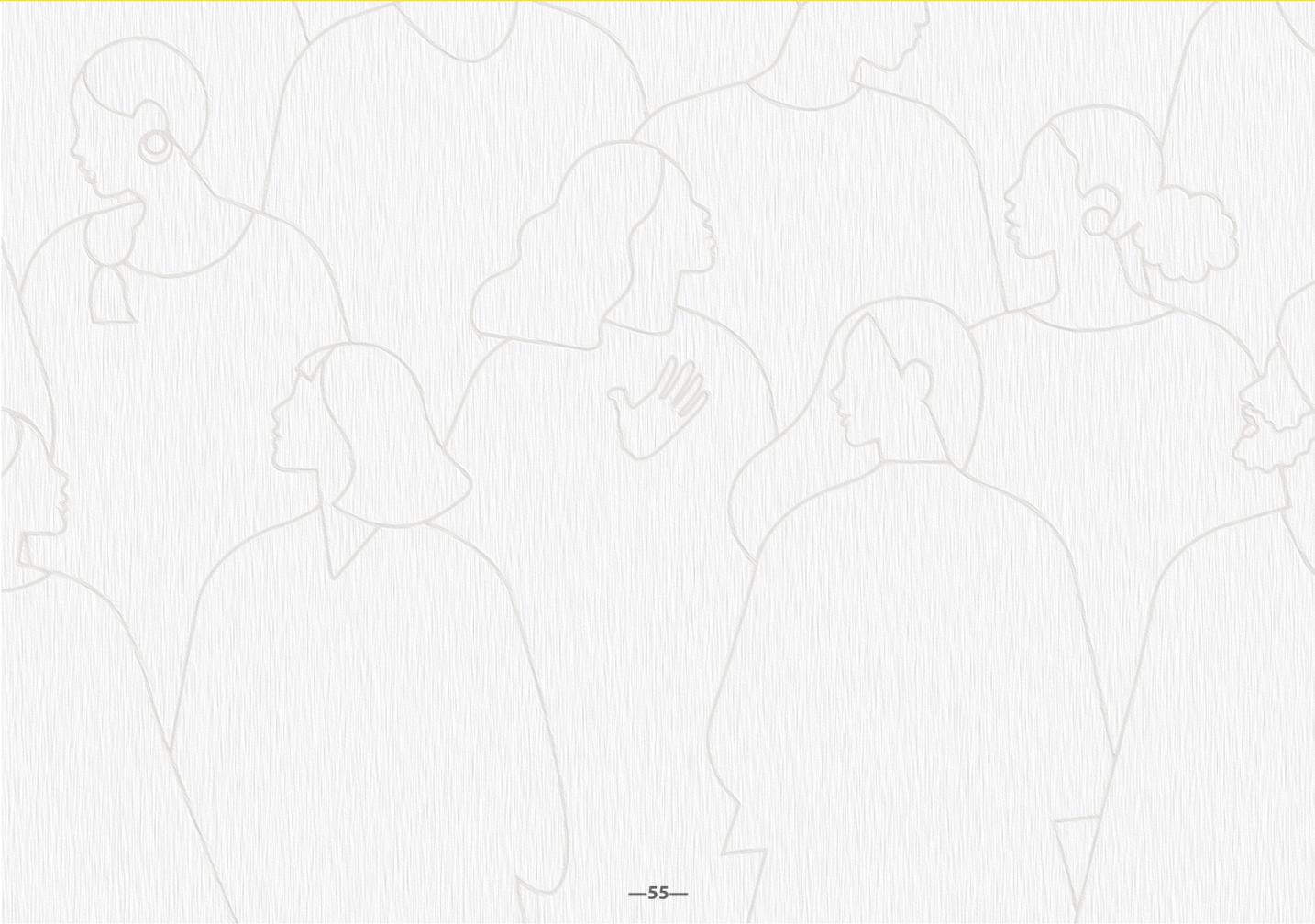
We will emphasize utility-focused equitable evaluation and intentional measurement to strengthen our strategy, so that we achieve our intended outcomes and identify any unintended consequences, both positive and negative. We will develop a core set of evaluation approaches, inclusive of process, summative and impact evaluation, and assessment tools (surveys, dashboards and metrics). These tools will ensure we identify, track and assess our progress, and measure both our process and our logic in a timely manner. It will support a constant process of iteration and evolution by identifying gaps, opportunities, successes and challenges across our strategy, and by applying equity-focused metrics and analyses. Central to this work is achieving clarity via logic-model

development for each strategic approach to implement right-size evaluation approaches, ensure collection and reporting of useful qualitative and quantitative data, identify our key stakeholders, design relevant and innovative metrics and monitor our progress on a routine basis.

Our aspiration is that by being intentional in evaluating and documenting our journey towards achieving our measures of success and measuring the associated outcomes, we will see things differently, plan differently, respond differently, and become more confident in the actions we take. Our experience will be shared and disseminated to key audiences to promote shared learning at a larger scale.



Section 3
Actions and accountability



Key accomplishments (2019–March 2021)



Approach	2019	2020	Until March 2021
Embed equity throughout the AMA enterprise	<ul style="list-style-type: none"> • April 2019, Aletha Maybank, MD, MPH started to as Chief Health Equity Officer and Vice President and launched the Center for Health Equity • Established Health Equity Workgroup comprised of representatives from each business unit of the management team to begin planning organizational change efforts • SVP, GVP, & VPs participated in 2-day Racial Equity Institute • Human Resources embedded diversity/inclusion and equity behaviors into the performance management factors for all employees to support the incorporation of equity from within the AMA • Launched the AMA Center for Health Equity SharePoint site on AMAtoday • Six Employee Resource Groups organically established for employees who identify as having disabilities, Black, Latinx, women, LGBTQIAA+, veterans • Office of General Counsel created the Law Firm Diversity & Inclusion Program to increase the AMA's retention of diverse outside counsel 	<ul style="list-style-type: none"> • AMA HOD passed three legacy antiracism policies: (1) Racism as a Public Health Threat, (2) Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice, (3) Racial Essentialism in Medicine • Completed an all-employee equity and engagement survey • Established individual business unit equity action teams • Health Solutions the first BU to hire Health Equity Program staff to support unit's HE efforts • Launched the Equity COVID-19 Resource Page on AMA website which consists of articles, commentaries, resource lists, etc., produced by global health and public health leaders, as it relates to the pandemic • Hosted an Equity in Advocacy three-part knowledge and skills building workshop series for Advocacy staff • Access Health Employee Resource Group hosted Disability 101 Series focused on basic concepts related to identifying as disabled, including stigma, etiquette, and explanation of Social vs. Medical Models of Disability, Disabilities at Work • Educational series delivered on gender identity and non-binary pronouns • Juneteenth recognized as an official AMA holiday 	<ul style="list-style-type: none"> • Launched cross-enterprise workgroups in communication equity, workforce equity, and sourcing and contracting equity

Approach	2019	2020	Until March 2021
<p>Build alliances & share power with marginalized physicians and other stakeholders</p>	<ul style="list-style-type: none"> • Deepened collaboration and partnerships with: National Medical Association, National Hispanic Medical Association, Student National Medical Association, Association of American Indian Physicians and the National Minority Quality Forum • Launched an Enterprise Social Responsibility program, in which AMA employees and their families volunteered 3,527 hours to support local neighborhoods 	<ul style="list-style-type: none"> • Launched Release the Pressure Campaign focused on hypertension control with National Medical Association, the Association of Black Cardiologists, the American Heart Association, the AMA Foundation (AMAF) and ESSENCE Communications • Released AMA Latinx Health Inequities Report on Latinx ethnic data to uncover the true magnitude of COVID-19 on the Latinx community • Launched the first AMA Spanish Spokesperson amongst AMA Ambassadors • Launched the Centering Equity in Emergency Preparedness and Response Initiative • Led judicial advocacy on equity issues such as banning menthol cigarettes (along with NMA), sugar-sweetened beverages, the opioid crisis, LGBTQ protections, reproductive justice, immigration-related issues, and evictions and housing, among others • Submitted a letter to the Department of Health and Human Services urging policymakers to require equitable demographic data in partnership with the National Medical Association, the National Hispanic Medical Association, the National Council on Asian Pacific Islander Physicians, the Association of American Indian Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics and the American College of Gynecologists • Sign on with leading organizations in medical education and health care opposing rule change effecting J-1 visa international medical graduates • Released a public statement denouncing racism and xenophobia, particularly as it impacts Asian Americans and Asian-presenting persons in America along with an accompanying public report arguing for the discrete data disaggregation of Asian American and Pacific Islander health outcomes • Convened 1st Physician Data Collaboration Summit for strengthening race and ethnicity data collection, a meeting with internal stakeholders across the AMA business units, and with external steering committee, including representatives from the ACGME and AAMC. Partners aligned to address data standards and definitions, research, data agreements and interoperability 	<ul style="list-style-type: none"> • Released a statement calling for a bolstering of REI data on COVID-19 vaccine distribution with American Nurses Association and the American Pharmacists Association • Convened the 2nd Physician Data Collaboration Summit for strengthening race and ethnicity data collection, a meeting with internal stakeholders across the AMA business units, and with external steering committee, including representatives from the ACGME and AAMC • Released statement, along with the American Nurses Association and the American Pharmacists Association, to physicians and other health care professionals strongly encouraging them to collect and report race and ethnicity information from patients when administering COVID-19 vaccines

Approach	2019	2020	Until March 2021
Push upstream to address all determinants of health	<ul style="list-style-type: none"> • Federal advocacy on maternal mortality and morbidity, social determinants of health, immigration, LGBTQ policy, protections related to health data, Title X family planning and augmented intelligence • State advocacy to authorize, reauthorize or maintain Medicaid coverage expansions in Arkansas, Georgia, Idaho, Montana and Utah • Advocacy issued a letter to the Centers for Disease Control and Prevention and the FBI and provided congressional testimony highlighting the endangerment of the transgender community 	<ul style="list-style-type: none"> • AMA formally joined Chicago's West Side United Collaborative as a social impact partner with \$2M upstream investment • Contributed to the revision of the 10 Essential Public Health Services to center equity convened by Public Health National Center for Innovations and the de Beaumont Foundation • AMA Past President Patrice Harris, MD, delivered Congressional testimony to the House Budget Committee Hearing, <i>Health and Wealth Inequality in America: How COVID-19 Makes Clear the Need for Change</i> • Testified to the U.S. Government Accountability Office to answer questions about the government's response to COVID-19 and inequities • Federal advocacy on police brutality, preparing for the next pandemic, and testimony to the Ways and Means committee on race and ethnicity data collection 	<ul style="list-style-type: none"> • Solicited applications for the Medical Justice in Advocacy Fellowship for 10 physicians, a partnership between AMA and the Satcher Leadership Health Institute • Selected five physician woman fellows from AMA for the Women's Wellness Equity and Leadership Fellowship, a collaboration of 10 physician associations: American Academy of Pediatrics (administrator), American Academy of Family Physicians, American College of Physicians, American Congress of Obstetricians and Gynecologists, American Hospital Association, American Medical Association, American Medical Women's Association, American Psychiatric Association, National Hispanic Medical Association, and National Medical Association, total cohort of 50 physicians • Released message to physicians and other health care professionals strongly encouraging them to collect and report race and ethnicity information from patients when administering COVID-19 vaccines • Letter asking CMS to maintain separate CPT codes for audio only visits to avoid exacerbating inequities
Ensure Equity in Innovation		<ul style="list-style-type: none"> • Convened AMA first external advisory committee on equity and innovation (quarterly meetings) • Created path to improve the diversity and inclusion or membership of Guides Panel 	<ul style="list-style-type: none"> • CPT Panel finalized proposal for BOT approval to expand panel composition to support diversity and inclusion • Completed equity lens review of current Guides Program • Explicit change to Digital Medicine Payment Advisory charter to include health equity

Approach	2019	2020	Until March 2021
<p>Foster truth, racial healing, reconciliation and transformation</p>	<ul style="list-style-type: none"> • Historic presidency of Patrice Harris, MD, the AMA's first Black women president as well as the AMA's first openly gay chair of the AMA Board of Trustees • Creation of the AMAF Vandenberg Health Equity Fund, which supports three unique scholarship categories, dedicated to health equity • Creation of the AMAF David and Donna Marie Meza Health Equity Fund with supports AMA and/or AMAF initiatives • AMAF funded pilot fellowship at the Icahn School of Medicine at Mount Sinai to address LGBTQ+ health care inequities • Creation of the Fellowship Commission on LGBTQ+ Health to lead the creation of the Request for Proposals process to formally launch the National LGBTQ+ Fellowship Program at the AMA Foundation • AMA Foundation continues its focus on health equity through grants to physician-led, community health organizations serving underserved populations, and scholarships to those underrepresented in medicine • AMA <i>Journal of Ethics'</i> issue dedicated to health care for undocumented immigrants—devoted significant time and resources highlighting AMA advocacy, resources and AMA-HOD policies on immigration 	<ul style="list-style-type: none"> • Published <i>NYT</i> Op-Ed on the pandemic's missing data highlighting the lack of race and ethnicity data • Aletha Maybank, MD, interviewed by host Oprah Winfrey, during a special presentation, "Oprah Talks COVID-19—The Deadly Impact on Black America," discussing the detrimental impact the COVID-19 pandemic on Blacks • Launched a YouTube-based conversation series "Prioritizing Health Equity" which centers the experiences of marginalized and minoritized physicians, public health leaders, and medical students during the COVID-19 pandemic (26 episodes produced by 2021) 	<ul style="list-style-type: none"> • AMA Center for Health Equity Research Director, Fernando De Maio published <i>Unequal Cities: Structural Racism and the Death Gap in America's Largest Cities</i> via Johns Hopkins University Press • AMA Foundation launches National LGBTQ+ Fellowship to increase the number of culturally competent medical specialists and further integrate LGBTQ+ health care curriculum into medical education

Proposed key actions (April 2021–2023)



The following is a list of our more specific actions and accountability over the next three years. This is not exhaustive and is iterative.

Approach	April 2021–2023	Examples of Accountability
<p>Embed equity throughout the AMA enterprise</p>	<p>Management team</p> <ul style="list-style-type: none"> • Create and implement an equity training curriculum and plan for training opportunities inclusive of gender & LGBTQ+ equity, anti-racism, and trauma-informed approaches, at minimum, for staff of AMA, JAMA and Health 2047 • Produce equity action plans for each AMA business unit • Establish requirements for all staff to include equity work in their objectives and standards and ensure inclusion of equity explicit performance factors • Develop a plan for AMA employment teams to recruit and diversify talent pool that reflects the racial and ethnic (most specifically Black, Indigenous, Latinx and people of color), LGBTQ+, and people with disabilities diversity of the nation, especially at the senior leadership level • Establish communities for learning amongst different cohorts of staff • Conduct a Data for Equity review to bolster capacity of AMA data systems to identify inequities • Develop a dashboard and track cross-management team benchmarks for organizational culture, practice and policy change for equity • Conduct yearly surveys to assess progress on equity, eliminating racism and other forms of oppression, engagement, and satisfaction goals and actions • Publish yearly report on the AMA's journey toward organizational change efforts to embed equity with best practices and lessons learned <p>Membership + Medicine (individual, group – health care institutions/systems, Section and Councils, the Federation)</p> <ul style="list-style-type: none"> • Establish and implement for the Board of Trustees an anti-bias, anti-racism curriculum • Conduct equity and engagement survey amongst AMA membership and produce a corresponding action plan. 	<ul style="list-style-type: none"> • Significantly improved diversity (racial, ethnic, sexual orientation, gender, age, disability) of leadership at AMA (management and membership) and JAMA; most specifically representation of Black, Indigenous, Latinx and people of color at the intersection identifying as women and/or LGBTQ+ • Implementation of an equity action plan by all business units • 100% of staff completed at least four formal equity-explicit training sessions reflected in individual objectives and standards • 100% of BOT participate in equity trainings • Increased knowledge and skills amongst AMA staff and Board in discussing equity topics as measured by the Equity and Engagement Assessment • Pulse surveys administered to track changes in culture and systems • Established internal AMA Data for Equity principles • Increased traffic to Health Equity Resource Center • Guidance created and provided to Federation on how to embed racial and social justice and equity and actively participate in a learning community • An active learning peer-community health care system established • Increasing viewership of equity-based modules on Health Equity Education Center (EdHub) • Improved data standards for race/ethnicity, sexual orientation and gender identity, and other key socio-demographic variables in the AMA Physician Masterfile and all AMA products; new capabilities for data harmonization with AAMC and ACGME as well as data sharing with external partners • Increased utilization of the AMA Physician Masterfile by external health equity researchers

Approach	April 2021–2023	Examples of Accountability
<p>Embed equity throughout the AMA enterprise continued</p>	<ul style="list-style-type: none"> • Develop a plan for AMA membership and its leadership, to reflect the racial and ethnic diversity of the nation and increase engagement and membership of Black, Indigenous and Latinx medical students and physicians • Launch and grow the Health Equity Education Center on AMA Ed Hub • Enhance already established online Health Equity Resource Center by designing and curating relevant content • Fortify and align health equity programming and advocacy/policy strategy with the Federation, other AMA members and external partners • Identify existing collaborative efforts (e.g., ACE consortium) to embed equity and anti-racist framing • Establish communities of learning with the Federation to embed racial and social justice and equity—identify and address challenges, and share wins, best strategies, and practices, and find opportunities for alignment • Develop tools and networks for health care institutions and systems to embed racial and social justice and equity throughout their institutions with a focus on quality and safety • Develop and implement plans to improve the quality, transparency, and access of AMA Physician Masterfile data on race/ethnicity, sexual orientation and gender identity, and other key socio-demographic variables to drive opportunities for health equity research and ensuring the diversity of the physician workforce 	
<p>Build alliances and share power with marginalized physicians and other stakeholders</p>	<ul style="list-style-type: none"> • Establish infrastructure and commit financial resources by which to continuously organize, exchange ideas, develop equity resources, set shared advocacy/policy agenda, and build rapport with historically marginalized and minoritized physicians and others in the health care ecosystem (midwives, doulas, etc.), health equity thought leaders, and other equity stakeholders • Lead key external, community-based partnership opportunities (e.g., “Release the Pressure,” West Side United partnership, Equity and Advocacy Report) that enable leveraging organizational power, sharing resources, and contributing to collective change • Renew financial investment and amplify West Side partnership that demonstrates commitment to reduce gap in life expectancy between West Side and the Loop • Develop best practices guidance on building multi-organizational alliances and sharing power to advance health equity in health care • Develop a national repository of state and specialty society policies, programs and other actions focused on studying, reducing and eliminating racial and ethnic health inequities and advancing racial justice • Identify and increase opportunities for joint advocacy (via letters, press statements, <i>amicus</i> briefs, lawsuits), with external stakeholders who are committed to advance equity and justice 	<ul style="list-style-type: none"> • Improved representation of marginalized (LGBTQ+) and minoritized (Black, Indigenous, Latinx) physicians within AMA membership proportionally to the demographic representation of the United States • Consistent and structured engagement with the National Medical Association, National Hispanic Medical Association, Association of American Indian Physician, GLMA, as well as the AMA Medical Student Section, AMA Minority Affairs Section, AMA IMG (International Medical Graduate) Section, AMA Senior Physicians Section, LGBTQT advisory Committee and Rural Physicians Committee • Increased knowledge, tools and practice of alliance building and power sharing to advance health equity • Normalized and consistent engagement with non-traditional local (e.g., West Side United) and national individual and organizational partners that are long-time recognized, credible leaders in leveraging health equity in policy and medical practice, including discrete shared deliverables, joint statements, and long-term evaluation of external-facing equity agendas • Amplification and replication of social impact investment models (community-driven), like West Side United, by the health care ecosystem via expansion of the Health Care Anchor Mission Network

Approach	April 2021–2023	Examples of Accountability
<p>Push upstream to address all determinants of health</p>	<ul style="list-style-type: none"> • Create and expand an online Upstreamist Certificate curriculum for publication on AMA Ed Hub™ for physician engagement and medical student engagement • Publish Structural Competency & COVID-19 Casebook, with accompanying AMA Ed Hub™ modules • Develop and distribute an anti-racism, health equity curriculum and accompanying tools using various AMA channels • Continue to strengthen and expand Health System Science pillar to include more content related to structural competency and public health • Launch train-the-trainers effort to enhance faculty capacity to teach on equity and anti-racism • Develop tools that equip physicians and health care systems/institutions to use public health epidemiology data that to render visible local patterns of health equity and inequity within cities, support population health efforts, and illuminate links between health outcomes to structural and social drivers • Launch a national challenge grant effort to gather insights and innovation on dismantling structural and institutional racism and advancing equity at the intersection of healthcare and public health systems and their neighboring geographic communities • Convene health care institutions to test and spread best practices for achieving organizational accountability to Upstreamist goals through data, metrics, quality, safety standards and benchmarks • Seek opportunities to improve public health through cross-sector collaboration guided by Upstreamist principles • Advance a new paradigm for health care as a key mover and driver of social and racial justice, by linking provider and health care system advocacy to other sectors, to effectively address both social and medical needs for populations and enhance understanding of and ability to detect and mitigate any unintentional worsening of inequities resulting from well-intentioned efforts • Equip physicians and health systems to enhance and assess their skills in providing high-quality care for marginalized communities (e.g., language-concordant or interpreter-mediated communication in non-English languages, cultural humility, training in public health communication strategies that target marginalized groups, etc.) 	<ul style="list-style-type: none"> • Strong interest and completion of the Upstreamist curriculum with modules on equity-informed high-reliability strategies, supported by public health and epidemiology data used and uploaded on AMA EdHub™ • Increased adoption and integration structural competency across education and the health care system • Increased use of local equity data (city and community level) to evaluate progress on population health indicators • National learning collaboratives (e.g., AMA-IHI Pursuing Equity), communities of practice, and/or racial justice and healing labs established and active • Standardized risk assessment and screening tools as a filter to reduce risk for worsening inequities utilized by health care systems • Increased cross-sector development of national equity and quality standards, benchmarks, incentive and reimbursement models

Approach	April 2021–2023	Examples of Accountability
<p>Ensure equity in innovation</p>	<ul style="list-style-type: none"> • Develop principles for equitable health innovation across AMA Enterprise • Identify and implement opportunities to embed racial and social justice and equity into existing AMA innovation strategies and initiatives including digital health, telemedicine, AI, medical education • Conduct market research to identify opportunities to center marginalized patients, innovators, and investors in health innovation • Support growth of equitable methods for engaging marginalized patients in the design and validation of health innovation solutions • Prioritize, invest in, and collaborate to advance research-driven opportunities to center marginalized patients, innovators, investors in health innovation • Develop resources and tools in response to baseline industry data to advance integration of equity into health innovation funding and resource allocation • Establish and engage with a collaborative of physician groups representing marginalized and minoritized physicians and communities • Launch health equity and innovation data collection and dashboard with collaborators to drive transparency and surface opportunities • Launch resources and tools in response to baseline industry data to advance integration of equity into health innovation funding and resource allocation • Publish biannual reports on improvement in metrics tracked in equity & innovation dashboard • Publish research findings and engage the health innovation community in dialogue about opportunities for positive change • Launch collaborative initiatives and programs in response to research, with continual feedback mechanisms in place with marginalized communities, innovators and investors to inform evolution 	<ul style="list-style-type: none"> • Equity principles are adopted by AMA innovation stakeholders across all business units and groups • At least 75 percent of internal innovation stakeholders engage in equity and innovation education and resources in 2021, with growth of content and engagement year-over-year • Opportunities to embed equity into innovation efforts are tracked and advanced over time, including methods for engaging marginalized patients in innovation solution design • Diffuse an equity-informed innovation strategy to other domains of the innovation ecosystem, including but not limited to health care policy, practice, technology, quality, and safety; research, medical education and health science; and organizational infrastructure including workforce capacity and finance • At least 1,000 external innovation stakeholders engage in equity & innovation education and resources in 2021, with growth of content and engagement year-over-year • External advisory group has consistent and meaningful interaction with AMA innovation stakeholders, providing guidance and accountability • Issue yearly shared advocacy agenda highlighting the needs and desires of physician groups representing marginalized and minoritized physicians and communities

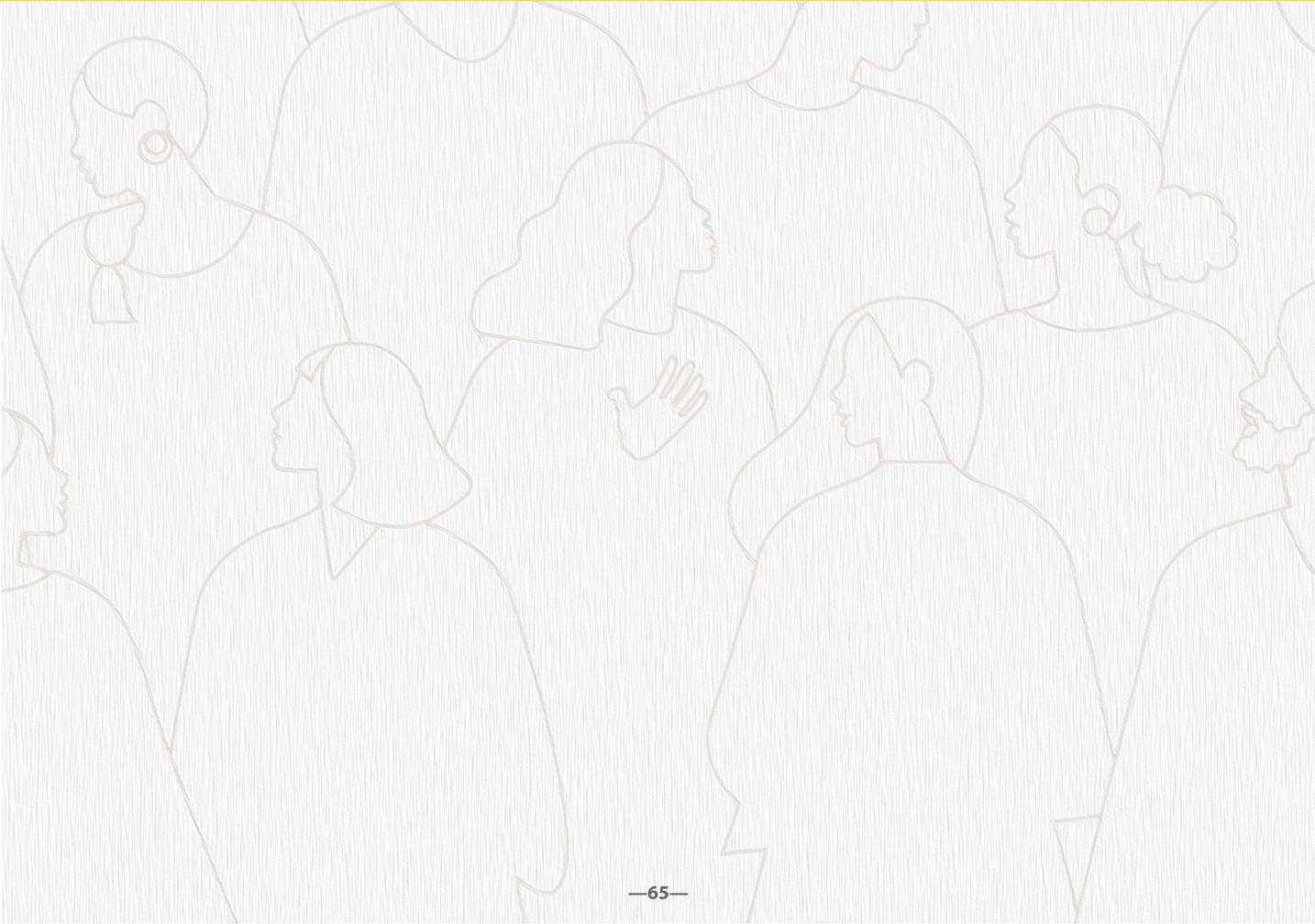
Approach	April 2021–2023	Examples of Accountability
<p>Foster truth, reconciliation, racial healing, and transformation</p>	<ul style="list-style-type: none"> • Launch a combined internal and external taskforce to guide, co-create plans for restorative justice for AMA's past • Host and structure restorative justice dialogues between AMA leadership and Black, Indigenous, Latinx and other physicians of color and their communities and families • Equip existing health care institutional partners (i.e., Hospital collaboratives, Federation associations and societies) with the knowledge and skill to develop institutional plans for acknowledgement, redress and closure • Evaluate opportunities to repair the harm caused by the Flexner report of 1910, such as the closing of five Black medical schools • Contribute to the discussion and evidence building on the impact of racist policies and practices in a wide variety of publications • Host well-profiled conversations on AMA's history (i.e., convos w/leading experts, authors, publications, etc.) • Launch, build and track AMA fellowship opportunity for AMA physicians in health equity and advocacy leadership • Continue and strengthen the AMA's Prioritizing Equity YouTube Series and identify other communication and marketing opportunities to use various mediums to amplify voices and ideas • Develop and partner on narrative projects that highlight experiences of physicians and communities most historically marginalized • Conduct research to understand, confront and dismantle dominant or malignant narratives (e.g., around race vs. racism) that appear in medical journals and all across health care • Conduct research to understand, confront and dismantle dominant or malignant narratives (e.g., around race vs. racism) that appear in medical journals and all across health care 	<ul style="list-style-type: none"> • Presence of publicly available educational modules on AMA's history on website and AMA assets • More accessible AMA Archives to public, researchers, etc., via four digital awareness campaigns • Inclusion of AMA historical context naming actions that may have caused harm • Recommendations implemented for initial phase of truth, reconciliation, and healing • Provide certificates of completion to 45 fellows • 75 percent of Fellows leading and participating in equity advocacy efforts • Continued meaningful engagement amongst and with alumni fellows • Prioritizing Equity and other media content created is considered a credible and relevant source for equity information • More physician associations and health care institutions using narratives as a form of data to influence change in culture and operations • Increased frequency and visibility of research studies published in medical journals that center equity, disrupt dominant narratives, expose harm from racism, and offer paths for healing

“There is a moment where you have to choose to be silent or stand up.”

—Malala Yousafza, Nobel Peace Prize laureate, education and girls rights activist, *He Named Me Malala*⁸¹



Section 4
Appendices



Appendix #1: Highlights of our AMA efforts to advance equity for all in the past 25 years

Our AMA Actions and House of Delegates [HOD] Policies

1998	H-350.974—HOD passes anti-discrimination policy: Racial and Ethnic Disparities in Health Care H-350.974, “...The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected...”
2003	Key collaborator and author (Former AMA President Alan R. Nelson, MD) of the landmark publication - Unequal Treatment which highlighted that racial bias towards their patients exists amongst and within physicians
2003	D-350.995—HOD passes Reducing Racial and Ethnic Disparities in Health Care
2004	Established the Commission to End Health Care Disparities, along with the NMA and the National Medical Hispanic Association
2008	H-350.960—HOD passes Underrepresented Student Access to US Medical Schools
2008	H-315.967—Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation
2008	H-350.975—Improving Healthcare of Hispanic Populations in the United States
2008	July 30, 2008—then Immediate Past AMA President Ronald M. Davis, MD, delivered an AMA apology (informed by a panel of experts) at the NMA National Convention
2009	H-350.959—HOD Passes Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities
2011	H-350.972—Improving the Health of Black and Minority Populations
2012	H-350.981—AMA Support of American Indian Health Career Opportunities
2013	H-350.976—Improving Health Care of American Indians
2016	H-215.965—Hospital Visitation Privileges for LGBTQ Patients
2017	D-90.992—Preserving Protections of the Americans with Disabilities Act of 1990
2017	H-440.869—Establishment of State Commission / Task Force to Eliminate Racial and Ethnic Health Care Disparities
2017	H-65.964—Access to Basic Human Services for Transgender Individuals
2018	H-65.963-Discriminatory Policies that Create Inequities in Health Care
2018	D-180.981—HOD passed AMA policy directing our AMA “to develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities”
2018	H-160.991—Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations
2018	D-315.974—Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms
2018	D-65.990—Utilization of “LGBTQ” in Relevant Past and Future AMA Policies
2018	H-440.818—Separation of Children From Their Caregivers at Border
2018	H-160.991—Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations
2018	H478.980—Increasing Access to Broadband Internet to Reduce Health Disparities
2018	H-295.897—Enhancing the Cultural Competence of Physicians (2018)
2018	H-440.816—Desired Qualifications for Indian Health Service Director (2018)
2019	H-295.878—Eliminating Health Disparities—Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education (2019)
2019	D-350.982—Racial and Ethnic Identity Demographic Collection by the AMA
2019	AMA Center for Health Equity was established with its inaugural Chief Health Equity Officer
2019	D-65.989—Advancing Gender Equity in Medicine
2019	H-65.961—Principles for Advancing Gender Equity in Medicine
2019	D-350.995—Reducing Racial and Ethnic Disparities in Health Care
2019	D-350.982—Racial and Ethnic Identity Demographic Collection by the AMA
2019	H-65.961—Principles for Advancing Gender Equity in Medicine
2019	H-350.974—Racial and Ethnic Disparities in Health Care
2019	D-65.989—Advancing Gender Equity in Medicine
2019	H-65.960—Health, In All Its Dimensions, Is a Basic Right
2020	AMA Board of Trustees acknowledges Racism is a public health threat and pledges to dismantle racism across the entire health care system

Our AMA Directives and Health Policies

D-255.982	Oppose Discrimination in Residency Selection Based on International Medical Graduate Status D-255.982	Our AMA: 1. Will request that the Accreditation Council for Graduate Medical Education include in the Institutional Requirements a requirement that will prohibit a program or an institution from having a blanket policy to not interview, rank or accept international medical graduate applicants. 2. Recognizes that the assessment of the individual international medical graduate residency and fellowship applicant should be based on his/her education and experience. 3. Will disseminate this new policy on opposition to discrimination in residency selection based on international medical graduate status to the graduate medical education community through AMA mechanisms.	Directives
D-255.995	Discrimination Against IMGs in Classified Advertising D-255.995	Our AMA will strongly encourage medical journals not to accept advertising that violates the nondiscrimination standard established in our AMA Bylaws ? 1.50.	Directives
D-295.962	Prevention of Harassment and Discrimination of Women in Medicine D-295.962	The AMA Model Harassment and Discrimination Grievance Policy and Procedure will be widely distributed throughout the medical education community and placed on the AMA Web site.	Directives
D-295.995	Adoption of Sexual Orientation Nondiscrimination and Gender Identity in LCME Accreditation D-295.995	Our AMA will urge the Liaison Committee on Medical Education to expand its current accreditation standard to include a nondiscriminatory statement related to all aspects of medical education, and to specify that the statement must address sexual orientation and gender identity.	Directives
H-255.966	Abolish Discrimination in Licensure of IMGs H-255.966	Medical Licensure of International Medical Graduates 1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs): A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations. B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice. C. Discrimination against	Health Policies
H-255.978	Unfair Discrimination Against International Medical Graduates H-255.978	It is the policy of the AMA to take appropriate action, legal or legislative, against implementation of Section 4752(d) of the OBRA of 1990 that requires international medical graduates, in order to obtain a Medicaid UPIN number, to have held a license in one or more states continuously since 1958, or pass the Foreign Medical Graduate Examination in Medical Sciences (FMGEMS), or pass the Educational Commission for Foreign Medical Graduates (ECFMG) Examination, or be certified by ECFMG. physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate. D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions. E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other	Health Policies

Continued on next page ...

Our AMA Directives and Health Policies

<p>H-255.978 <i>continued</i></p>		<p>relevant organizations. When available, the results should be a part of the determination of eligibility for licensure. 2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates. 3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs. 4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.</p>	
<p>H-285.985</p>	<p>Discrimination Against Physicians by Health Care Plans H-285.985</p>	<p>Our AMA: (1) will develop draft federal and model state legislation requiring managed care plans and third party payers to disclose to physicians and the public, the selection criteria used to select, retain, or exclude a physician from a managed care or other provider plans; (2) will request an advisory opinion from the Department of Justice on the application of the Americans with Disabilities Act of 1990 to selective contracting decisions made by managed care plans or other provider plans; (3) will support passage of federal legislation to clarify the Americans With Disabilities Act to assure that coverage for interpreters for the hearing impaired be provided for by all health benefit plans. Such legislation should also clarify that physicians practicing in an office setting should not incur the costs for qualified interpreters or auxiliary aids for patients with hearing loss unless the medical judgment of the treating physician reasonably supports such a need; (4) encourages state medical associations and national medical specialty societies to provide appropriate assistance to physicians at the local level who believe they may be treated unfairly by managed care plans, particularly with respect to selective contracting and credentialing decisions that may be due, in part, to a physician's history of substance abuse; and (5) urges managed care plans and third party payers to refer questions of physician substance abuse to state medical associations and/or county medical societies for review and recommendation as appropriate.</p>	<p>Health Policies</p>
<p>H-295.865</p>	<p>Discrimination Against Patients by Medical Students H-295.865</p>	<p>Our AMA opposes the refusal by medical students to participate in the care of patients on the basis of the patient's race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity.</p>	<p>Health Policies</p>
<p>H-295.969</p>	<p>Nondiscrimination Toward Residency Applicants H-295.969</p>	<p>Our AMA urges the Accreditation Council for Graduate Medical Education to amend its Institutional Requirements to read: "In assessing and selecting applicants for residency/fellowship programs, ACGME-accredited programs must not discriminate on the basis of sex, age, race, creed, national origin, gender identity, or sexual orientation."</p>	<p>Health Policies</p>
<p>H-305.971</p>	<p>Discrimination Against Resident Candidates Based on Graduate Medical Education Medicare Funding H-305.971</p>	<p>The AMA urges residency programs to use the qualifications of residency applicants as a basis for filling available positions, and not the eligibility or level of future Medicare graduate medical education funding.</p>	<p>Health Policies</p>

Our AMA Directives and Health Policies

<p>H-310.919</p>	<p>Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919</p>	<p>Our AMA: 1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion; 2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process; 3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants; 4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and 5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.</p>	<p>Health Policies</p>
<p>H-310.923</p>	<p>Eliminating Religious Discrimination from Residency Programs H-310.923</p>	<p>Our AMA encourages residency programs to: (1) make an effort to accommodate residents' religious holidays and observances, provided that patient care and the rights of other residents are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious holidays and observances.</p>	<p>Health Policies</p>
<p>H-310.976</p>	<p>Gender-Based Questioning in Residency Interviews H-310.976</p>	<p>The AMA (1) opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination; (2) supports inclusion in the AMA Fellowship and Residency Interactive Database Access (FREIDA) system information on residency Family and Medical Leave policies; and (3) supports monitoring the Accreditation Council for Graduate Medical Education as it proposes changes to the "Common Requirements" and the "Institutional Requirements" of the "Essentials of Accredited Residencies," to ensure that there is no gender-based bias.</p>	<p>Health Policies</p>
<p>H-350.953</p>	<p>Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data H-350.953</p>	<p>Our AMA will: (1) oppose policies that enable racial housing segregation; and (2) advocate for continued federal funding of publicly accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and health care, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool.</p>	<p>Health Policies</p>
<p>H-430.982</p>	<p>Appropriate Placement of Transgender Prisoners H-430.982</p>	<p>1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoner's genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status. 2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.</p>	<p>Health Policies</p>

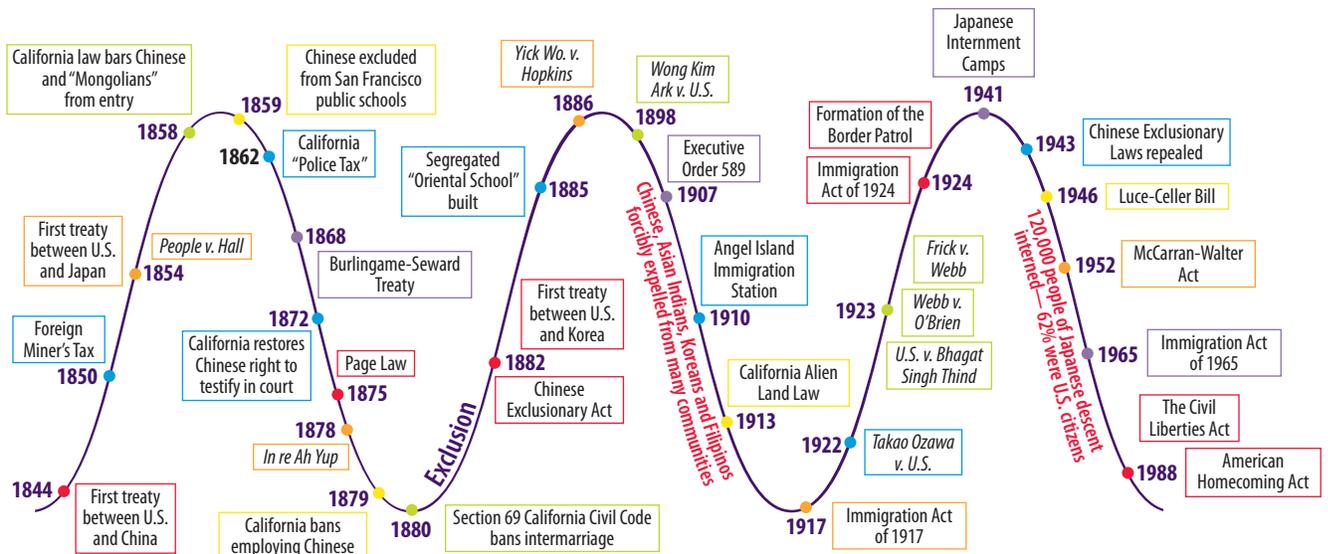
Appendix #2: Race and racism definitions table*

	Definitions	Notes
Race	System of categorizing people that arises to differentiate groups of people in hierarchies to advantage some and disadvantage others. Stated another way, race is a social construct or “a symbolic category (actively created and recreated . . . rather than pre-given), based on phenotype or ancestry and constructed to specific racial and historical contexts, that is misrecognized as a natural category.”	The modern consensus of evolutionary biologists is that our species does not have enough genetic variability among its populations to justify either the identification of geographically based races or of evolutionarily distinct lineages.
Ethnicity	Ethnicity is a complex construct that includes biology, history, cultural orientation and practice, language, religion, and lifestyle.	The lack of major systematic genetic differences between ethnic groups, together with the extensive differences in lifestyle (diet, alcohol, housing, smoking, etc.), means that ethnic differences in mortality and morbidity to some extent provide evidence against the importance of genetic factors and for the importance of environmental factors.
Genetic / Biologic Ancestry Root Causes	The proportion of recent ancestry displayed in an individual via genetic material inherited from one’s ancestral geographic origins. Underlying systems and structures of social injustice that generate health inequity over time, including white supremacy, patriarchy, and class oppression. They interact with each other to produce social exclusion, marginalization, and exploitation.	In a clinical setting, for instance, scientists would say that diseases such as sickle-cell anemia and cystic fibrosis are common in those of “sub-Saharan African” or “Northern European” descent, respectively, rather than in those who are “black” or “white.”
Racism	As defined by Camara Jones, “racism is a system of structuring opportunity and assigning value based on phenotype (‘race’), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and undermines realization of the full potential of the whole society through the waste of human resources.”	Racism can operate at different levels: structural, institutional, interpersonal, and internalized.
Structural Racism	As defined by Zinzi Bailey et al, structural racism “refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources.”	
Institutional Racism	Discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race.	Individuals within institutions take on the power of the institution when they act in ways that advantage and disadvantage people, based on race.
Interpersonal Racism	The expression of racism between individuals. These are interactions occurring between individuals that often take place in the form of harassing, racial slurs, or racial jokes.	It may also take more subtle forms of unequal treatment, including micro-aggressions.
Internalized Racism	Acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth.	

* This table was created by staff members at the Center for Health Equity of the American Medical Association with adaptations from Bailey et al. 2017; Lawrence, 2004; David Wellman, and Jones, 2000, Greenwald & Banaji, 1995).

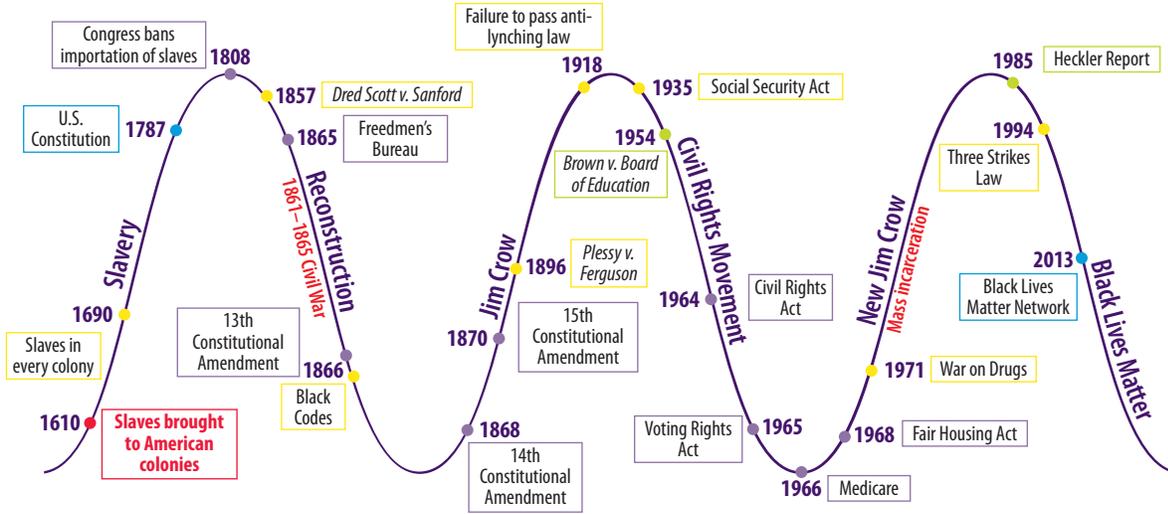
	Definitions	Notes
Prejudice	An unfavorable opinion or feeling formed beforehand or without knowledge, thought, or reason.	Prejudice also means an action in the sense that they are sequential steps by which an individual behaves negatively toward members of another group: verbal antagonism, avoidance, segregation, physical attack, and extermination. The term “prejudice” also refers to unfavorable opinions or feelings which lead groups to view members of other social groups as threatening adversaries who are inherently inferior or are actively pursuing immoral objectives.
Bias	<p>A form of prejudice in favor of or against one person or group compared with another usually in a way that's considered to be unfair to one group. Biases may be held by an individual, group, or institutions and can have negative or positive consequences and oftentimes are learned behaviors or habitual thoughts. Biases often emerge in relation to race/ethnicity, gender, socioeconomic status, ability status, LGBTQ+ identity, literacy, amongst other groupings.</p> <p>There are two main types of biases discussed in scholarly research and in medicine that inhibit progress towards multiculturalism and equity in our society:</p> <ol style="list-style-type: none"> 1. Explicit or Conscious bias—This refers to the attitudes and beliefs we have about a person or group on a conscious level, that is we are aware and accepting of these beliefs, and they are usually expressed in the form of discrimination, hate speech or other overt expressions. 2. Implicit or Unconscious bias—This refers to the unconscious mental process that stimulates negative attitudes about people outside one's own 'in group'. For example, implicit racial bias leads to discrimination against people not of one's own group. Extensive research supports the notion that we all hold unconscious beliefs about various social and identity groups, and these biases stem from one's tendency to organize social worlds by categorizing and are influenced by power dynamics in a society. 	It is important to note that biases, both explicit and implicit, have to be unlearned at the individual, group and institutional level in order to mitigate negative consequences as a result of existing and prevailing biases. Both first require an awareness and acknowledgment that the bias exists and require personal, group and institutional action to eliminate these biases.

Appendix #3: Structural violence and Asian community



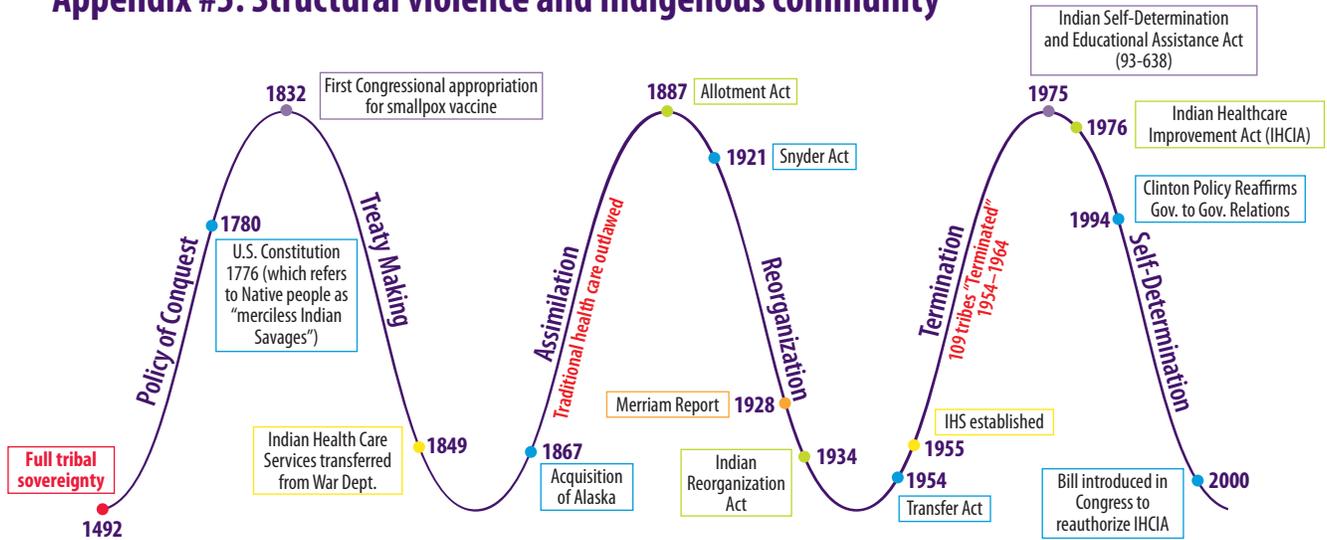
This graphic was created by staff members at the AMA Center for Health Equity.

Appendix #4: Structural violence and Black and/or African American community



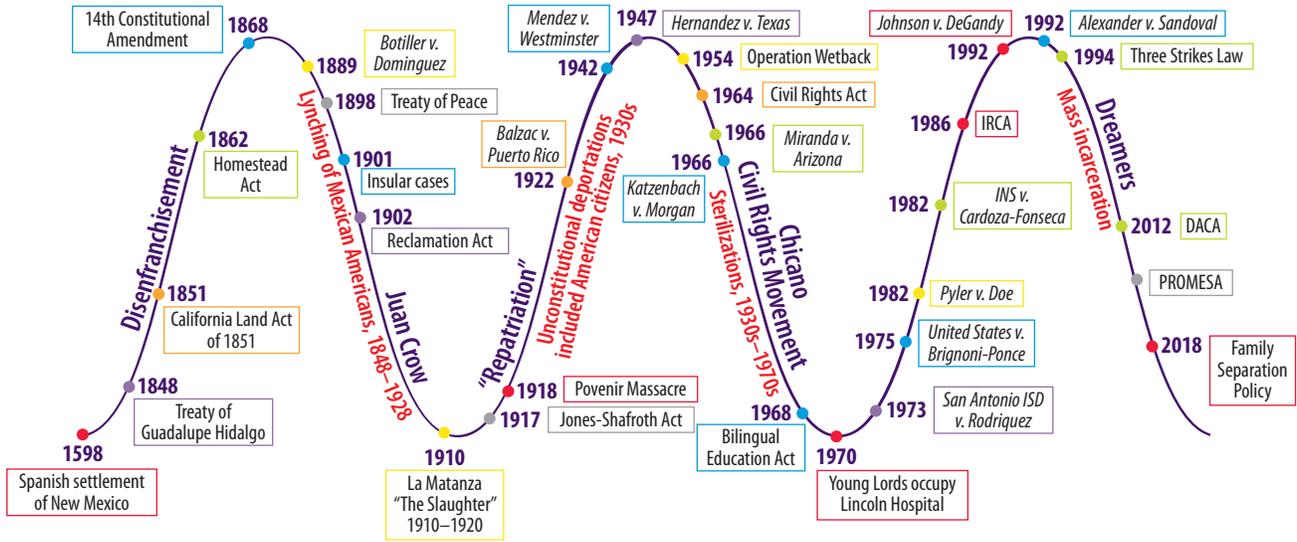
This graphic was created by staff members at the AMA Center for Health Equity.

Appendix #5: Structural violence and Indigenous community



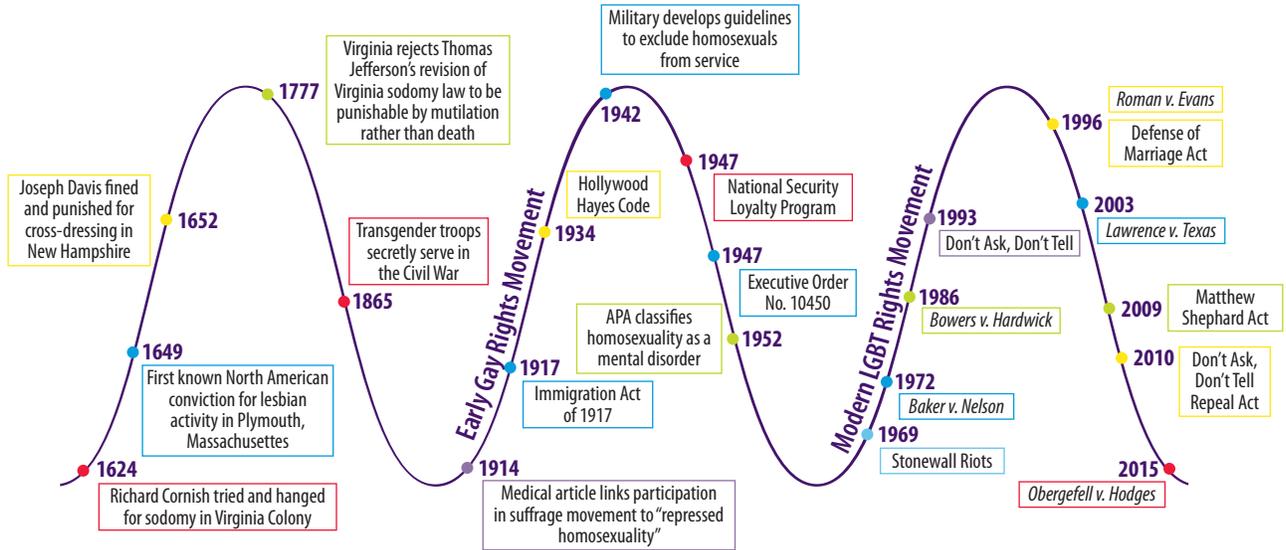
This graphic was created by staff members at the Center for Health Equity at the American Medical Association. It was adapted from: Shelton, B. L. (2004, February). Legal and historical roots of health care for American Indians and Alaska Natives in the United States (Issue brief). Kaiser Family Foundation, pp 2. <https://www.kff.org/wp-content/uploads/2013/01/legal-and-historical-roots-of-health-care-for-american-indians-and-alaska-natives-in-the-united-states.pdf>

Appendix #6: Structural violence and Hispanic/Latino/Latina/Latinx community



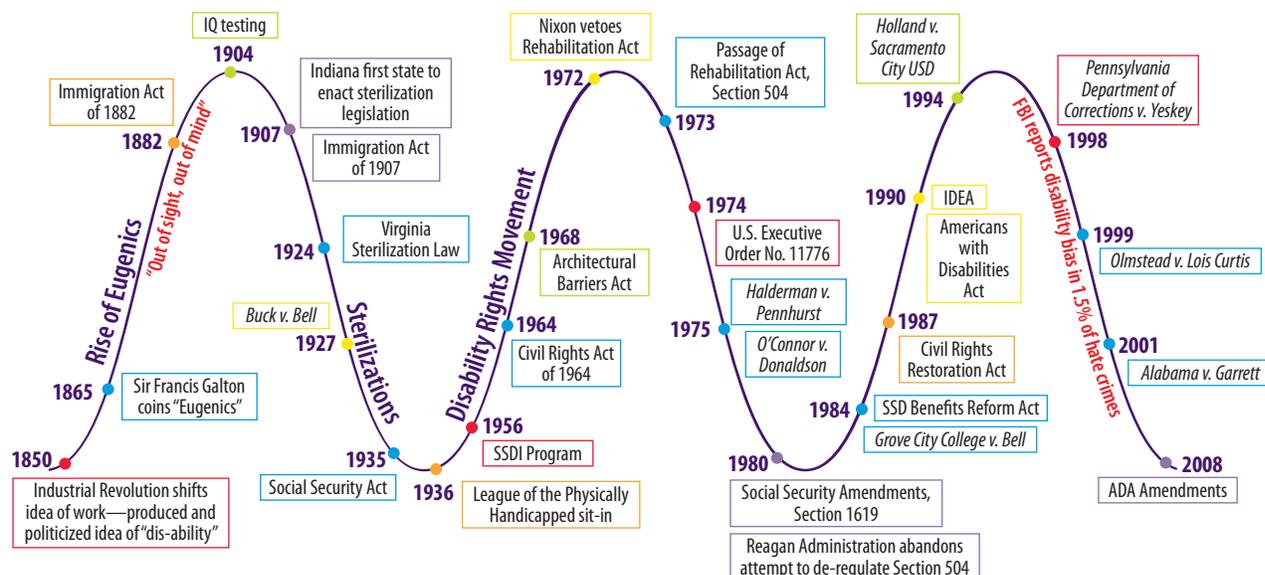
This graphic was created by staff members at the AMA Center for Health Equity.

Appendix #7: Structural violence and the LGBTQ+ community



This graphic was created by staff members at the AMA Center for Health Equity.

Appendix #8: Structural violence and People with Disabilities



This graphic was created by staff members at the AMA Center for Health Equity.

Appendix #9: AMA's historical harms—look back (1847–1997) additional insights

General:

- 1850 Transactions include a table using phrenology and cranium size to differentiate races:
 - [1850 Transactions of AMA—Report of the Committee on Medical Science \(Digital Archives\)](#)
- 1860 Transactions—There are many, many, many troubling things to be found in this article on idiocy, but it is enough to say that this is a piece of work that can only be described as proto-Eugenic:
 - [1860 Transactions of AMA—Report on the Education of Imbecile and Idiotic Children \(Digital Archives\)](#)
- 1907 Annual—This is one of many instances in which the AMA is actively involved in assisting colonial and military pursuits: “The Status of medical service in the isthmian canal zone”
 - [1907 Annual—Report of the Committee on Medical Legislation \(Digital Archives\)](#)
- 1930s HOD—In the 1930s the AMA argued over an immigration provision that exempted immigrant physicians from the quota system. Many believed there was already an overabundance of physicians and, essentially, that it wasn't fair because American physicians weren't allowed to practice in Europe.
 - [1935 Special Session HOD—Resolutions on Immigrant Physicians \(Digital Archives\)](#)

Asian-American:

- Asian health practices are decried as barbaric and cruel. Medicine also seems to have been wielded as a missionary tool. When the Chinese began to question Western health practices, there was finally a discussion in 1891 of the need to perhaps be more transparent with the Chinese government and its people.
 - [1891—Medical Crisis in China: the field for medicine in the orient \(JAMA\)](#)
- In an 1895 *JAMA* article, the Chinese are described as “Oriental barbarian[s]”. Interestingly, article also discusses raising funds to erect a statue of J. Marion Sims, noted for his experiments on enslaved women.
 - [1895—A Holiday Hint to the Rush Monument Committee \(JAMA\)](#)

- In 1972, the BOT approved a plan to send a delegation to China to learn about acupuncture as a form of anesthetic.
 - However, the transition to accepting acupuncture was far from seamless: [1985—Maintenance of Professional Authority \(Journal—Social Problems\)](#)
 - Prior to 1972, there is no mention of Chinese acupuncture in the HOD proceedings. Even then, it was still researched under the purview of medical quackery—[1972 Clinical Convention—Report of OGC \(Digital Archives\)](#)

Native American:

- 1852 Transactions of AMA—discussing immunity to certain diseases, it is noted that “the imperfect domestication or civilization of our red men has seemed to unfit them for residence in the very forests, prairies, and morasses, of which they are original denizens”
 - [1852 Transactions of the AMA—On the Blending and Conversion of Types in Fever](#)
- 1860 Transactions of the AMA: the Native American is described “savage in his head and in his heart”. It is said that as a people they are mendacious and have a propensity for thieving and cruelty.
 - [1860 Transactions—Report on the Topography and Epidemics of New York](#) (Digital Archives)
- 1929 BOT: The AMA worked closely with the Indian Bureau and other government medical service programs for Native Americans.
 - [\(BOT minutes 2-21-1929\)](#)
 - While they did genuinely want to improve the health of Native Americans, their insistence on using Western medical practices furthered the overall goal of eliminating Indigenous culture. [Unsettling Indian Health Services \(University of New Mexico thesis\)](#)
- 1950s—AMA meetings seemed to frequently involve “Indian dance” performances
 - [\(Daily Bulletin 12-3-1952\)](#)
- 1990 Annual—the AMA HOD decided it was important to let adults refuse medical treatment for religious beliefs, recognizing the importance of native healers, while simultaneously undermining the legitimacy of these healers
 - [1990 Annual—BOT Report H](#)

Latinx:

A Note on Historical phrasing of Hispanic/Latino/ Latinx: (contributes to harm of no specific data-collection)

- [1850 Transactions of AMA—Report of the Committee on Medical Sciences \(Digital Archives\)](#) uses phrenology/cranium size to rank peoples of the world:
 - “2. The nations having the smallest heads are the ancient Peruvians and Australians. 3. The barbarous tribes of America possess a much larger brain than the demi-civilized Peruvians or Mexicans.”
- 1903 *JAMA*—In a *JAMA* letter extolling the benefits of yurba mate (or Peruvian tea), the writer states: “It seems to be a fact that the ordinary South American or hybrid South American is not naturally an energetic individual, but under the influence of this physical and mental stimulant the amount of hard work that he can do is hardly limited.” [1903 \(JAMA\)—Paraguay tea](#)
- [1910 Annual HOD—affiliate membership granted to canal zone medical society](#)
 - AMA votes to accept the application of the Medical Association of the Isthmian Canal Zone as an affiliate member organization—that society represented 72 physician members in 1911. The public

health efforts to eliminate Yellow Fever (and related mosquito eradication) in this area were largely successful, but came about as a result of the colonial claims the US made involving itself in the Panama Canal creation, extending American influence across the canal.

- [1929 JAMA Article: The term 'Mexican'](#) discusses this issue of nomenclature and a distinct race:
 - “In these bulletins I have noted that the term “Mexican” is used incorrectly as denoting a certain race or color. In the interest of uniformity and truth in the basis of classification in vital statistics, I take the liberty to discuss the subject. In Mexico there are many white inhabitants with Mexican nationality, chiefly of Spanish origin. The rest of the population is composed of pure Indians, mixed Indians and white, negro, mixed negro and white (mulatto) and mixed Indian and negro.”
- According to the [Pew Research Center, census records from 1930](#) show that in that year, the government counted Latinx people under the catchall category “Mexican.” The idea that all people of Latin descent were labeled as Mexican is perplexing considering that the U.S. took control of Puerto Rico as a territory in 1898.
- [1941 JAMA Article—Our population](#) reveals even in 1941 “Mexicans” were included as white:
 - “In 1940 the net reproduction rate of the **white population (including the Mexicans)** had dropped to about 95 from a rate of about 111 in 1930, while that for the nonwhite population declined to 107 in 1940 from 110 in 1930.”
 - Harm in this case comes from our lack of specific data-collection and attention.
- According to Pew, it wasn't until [1970 that the Census Bureau asked](#) people living in the U.S. if they were either “Mexican, Puerto Rican, Cuban, Central or South American, Other Spanish” or “No, none of these.”
- [1947—History of the AMA 1847-1947 \(Digital Archives\)](#) Mexicans described as “lackadaisical”, “not wholly stupid”:
 - “The Mexicans, who are not wholly a stupid people, built tall steel towers south of [American] stations so that the broadcasts had very little circulation in Mexico.”
- [1954 JAMA Article—Social Security for Physicians](#) article complains that “unskilled Mexican laborers” earn more than doctors on Park Ave in discussion of the danger of extending social security to the medical profession. Appears to indicate our recognition of this group as marginalized:
 - “An unskilled Mexican laborer told me that he makes \$17 a day. According to recent report in Medical Economics, some physicians on Park Ave. in New York City do not make that much, and I am sure that there are quite a few others throughout the country who put service before remuneration and do not earn that much.”

Anti-Semitism:

- 1892 *JAMA* article: describing Russian Jewish immigrants to America: “He is a man who probably has never washed in his life”
 - [1892—The immigrant ships and other points of marine hygiene \(JAMA\)](#)
- 1894 *JAMA* letter to the editor—accuses Jewish pharmacists of selling snake oil:
 - “The difference between these and American secretly prepared pharmacy products is that one is from abroad and probably of Hebrew manufacture, while the others are indigenous.” [1894—The Advertising Question \(JAMA\)](#)
- 1905 *JAMA* article: Jews have somehow become resistant to most disease because they have lived in cities for so long and the weakest among them have been culled:
 - “Insurance men, however, it is alleged, while recognizing the temperance of the Jews as a factor, are

inclined to think that this longevity is a result of natural selection, the weaker elements of the Jewish race having been gradually eliminated during centuries of persecution. There is still another possible factor to be considered. For centuries the Jews have become acclimatized, so to speak, to city life, and therefore may represent the class most resistant to such environment.” [1905—Longevity of Jews \(JAMA\)](#)

LGBTQ+:

- In 1896, there is a discussion in the HOD proceedings of homosexuals (also called “sexual perverts”) saying that if their “attachments” get too strong, family and friends should legally break them up. Also that these “attachments” may lead to blackmail. Finally, discusses homosexuality as a psychiatric disorder and a crime.
— [1896 Annual—HOD Association News \(Digital Archives\)](#)
- 1913 *JAMA* article describes homosexuality as “abhorrent”, among other things
— [August 1913—The Conception of Homosexuality \(JAMA\)](#)
- A 1928 *JAMA Neurology & Psychiatry* article posits that epilepsy is caused by poorly repressed homosexuality
— [October 1928—Is there an epileptic personality make-up? \(JAMA Archives Neurology & Psychiatry\)](#)
- In 1941, an article in *JAMA* posits that after years of study, they have established that homosexual behaviors are a result of an “inability to meet the responsibilities of establishing and maintaining a home”
— [August 1941—Sex Variants: A Study of Homosexual Patterns \(JAMA\)](#)
- 1973 Annual—Yet another case of deferred action. HOD and Council on Mental Health agree that it should be illegal to discriminate on the basis of homosexuality, but ultimately do not take action against discrimination and instead opt to encourage education for physicians.
— BOT Report K: “At its meeting in June 1973 the House of Delegates referred to the Council on Mental Health Resolution 28 which dealt with legal restrictions on sexual behavior between consenting adults and discrimination against homosexuals. **The resolution called on the AMA to support the American Law Institute Model Penal Code and to favor an end to legal and employment discriminatory practices.** In Report K, **the Council on Mental Health concurs** in the position of the American Law Institute, as stated in the Model Penal Code, **that private sexual conduct between consenting adults is a concern of the individuals involved and should not be subject to criminal penalties. The Council, however, deferred action on the subject of discrimination against homosexuals pending further study.** Your Reference Committee commends the Council on Mental Health for its efforts to come to grips with a subject that has profound social, ethical and medical implications. The Committee also recognizes that any consideration of legal restrictions on sexual behavior cannot exclude homosexual behavior and that the Council on Mental Health is continuing to study homosexuality.”
— BOT Report L: “Report L reviews and commends the work of the former AMA Committee on Human Reproduction and cites the continuing need for physician competence in dealing with problems of sexuality and family counseling. **The report recommends that the AMA encourage formal instruction of physicians in human sexuality at all three levels of professional education: undergraduate, graduate and continuing education.**” [1973 Clinical Convention BOT Report L \(Digital Archives\)](#)
- Our AMA was the frequent target of ACT UP protesters for our stance against universal health care (which made it more difficult for marginalized people to get health coverage).
— [April 1990—129 Seized in downtown AIDS protest \(Chicago Tribune\)](#)

Appendix #10: Efforts to advance equity—turning a page (1924–2007) additional insights

General

- In 2004, the AMAF launched the Minority Scholars Award and continued until 2017 when the program evolved to the **Underrepresented in Medicine Scholarship to support** BUPOC medical students who demonstrate a dedication to serving vulnerable or underserved populations.

Native Americans:

- 1924 BOT—The AMA was particularly concerned with the development of Trachoma in Native American populations and worked hard to ensure their health needs were met.
- 1979 BOT—The AMA set about specifically sending doctors to places that needed them most in the 1970s with Project USA. This included Indian reservations and Puerto Rico, among other places.
 - Also applicable to Latinx ADDRESSING INEQUITIES re: Puerto Rico and other areas

Latinx:

- Discussion of breaking down barriers for “Anglo-Hispanics”:
 - [1982 Annual HOD](#) – BOT Report CC: “Near completion is a study of cultural and communications barriers to optimal outcomes of the Anglo-Hispanic therapeutic encounter. Reports will be available in Fall of 1982.”
 - [1982 Interim HOD](#)—BOT Report A: “A special effort is now being made to reach the Spanish-speaking public. A cross-cultural patient and health education program is now being developed and the hiring of a Spanish-speaking physician is planned.”
- [1998 JAMA Pediatrics—Access Barriers to Health Care for Latino Children](#)
 - Article points out a lack of study on health care issues of Hispanic children (which gets to the real issue—**that they were essentially just ignored by organized medicine**).
 - “Despite the size and rapid growth of the US Latino population, little is known about access barriers to health care for Latino children. In an extensive review of the literature on access barriers for Latino children, Flores and Vega found no published studies that focused on barriers to care as perceived by Latino parents. Previous work has been limited by frequent reliance on secondary data sets, the rarity of analysis by pertinent major Latino subgroups, an emphasis on adults, and infrequent attention to the importance of barriers associated with language and culture.”
 - BEFORE this 1998 article, most AMA discussion of “Mexicans” refers to a Mexican delegation of doctors or the Mexican Medical Society. By 1893, members of medical societies in both Mexico and Canada were allowed to join the AMA. It was all fairly respectful in tone, perhaps due to the way we included Mexican under the category of white for so long.
- In 2008, in response to a theory that all doctors should learn medical Spanish, the *Journal of Ethics* recommends that medical students should be taught how to work with interpreters
 - [2008 April \(Journal of Ethics\)—Should all US physicians speak Spanish](#)

LGBTQ+:

- HOD discussed providing sensitive medical care to LGBTQ+ patients in 1981:
 - “Whether lesbians or homosexual males are happy with their sexual orientations or not, they do require and deserve physician-patient relations that are marked by trust, acceptance and understanding. The physician can contribute to this by remaining sensitive to the possibility that patients, particularly those with suspicious lesions, may have a homosexual orientation and by

cultivating a nonjudgmental professional approach toward obtaining a sexual history. The physician who feels uncomfortable with homosexual people should develop access to appropriate referral channels.” [1981 Annual HOD—Council on Scientific Affairs Report B \(Digital Archives\)](#)

- In 1986, AMA devoted the front page of *The Reporter* (internal AMA employee newsletter) to calming fears of sharing a workplace with HIV/AIDS positive individuals
- In 2004, AMA President John Nelson, MD, stated in an interview that private institutions have the right to set and enforce its own policies. This statement was in reference to New York Medical College’s decision to revoke the charter of its LGBT medical student group. The AMA did not support the ban, and the organization released a statement stating the president’s views were not representative of AMA policy. As a response, Dr. Nelson issued an apology statement indicating his views “were grossly misrepresented” and “apologize to anyone who may have been offended by what they read.” This apology statement was not accepted by GLMA.
- HOD adopted an official non-discrimination policy against LGBTQ in 2004:
 - “RESOLVED, That our American Medical Association encourage physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include “sexual orientation, sex, or perceived gender” in any nondiscrimination statement; and be it further
 - RESOLVED, That our AMA encourage and work with state medical societies to provide a sample printed nondiscrimination policy suitable for framing, and encourage individual physicians to display for patient and staff awareness—as one example: “This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or perceived gender.” [2004 Annual—Resolution 414 \(Digital Archives\)](#)
- which was followed by an apology from our then President in 2005 to GLMA:
 - “I know that GLMA members and LGBT physicians have been treated unfairly by the AMA in the past. There is simply no excuse for discriminatory actions or exclusions based on sexual orientation or gender identity—none.” He continued, “First, GLMA has opened [the AMA’s] eyes to the diverse needs of LGBT patients, and second—and just as important—GLMA has told patients that they have the right to expect a health care system filled with openness, fairness and equality.” [September 2005—AMA President Makes historic first appearance at GLMA Conference \(GLMA\)](#)

Actions Regarding Interpreters/Translators:

- 1990 Interim HOD—not until 1990 did AMA HOD recommend translator services in hospitals. The book *The Spirit Catches You and You Fall Down* details the many ways medical care can go wrong when patients and doctors are unable to understand each other. This book is particularly about the Hmong community, but it applies to all immigrant groups.
 - [1990 Interim—Resolution 108 translator services in hospitals \(Digital Archives\)](#)
- In 2007, the JOE recommends teaching doctors to work with real interpreters and cultural competency:
 - [2007—Language Barriers and the Patient Encounter \(Journal of Ethics\)](#)

Appendix #11: Overview of social and health inequities

	Total	White non-Hispanic	Asian	Hispanic or Latino	Black non-Hispanic	Native American or Alaska Native	Other/two or more races non-Hispanic
Population (2019) ¹	328,239,533	197,309,822	18,905,879	59,639,869	41,147,488	2,434,908	7,273,281
Wealth: median household assets (2016) ²	\$692.01k	\$929,840	NR	\$191,430	\$138,060	NR	\$457,690
Unemployment rate (Oct 2020) ³	6.9 %	6 %	7.6 %	8.8 %	10.8 %	NR	NR
Percent of people in poverty, all ages (2019) ¹	10.5 %	10.5 %	7.3 %	15.7 %	18.8 %	NR	NR
Racial and ethnic groups as a percent of total prison population (2019) ¹	1,430,805	30.47 %	NR	23.23 %	32.8 %	NR	NR
Total number of hate crimes motivated towards specific race, ethnicity or ancestry groups (2019) ¹	3,963	666	179	527	1,930	119	542*
Percent of people covered by public or private insurance (2019) ⁴	92 %	94.3 %	93.8 %	83.3 %	90.4 %	NR	NR
Rate of uninsured, adults aged 18-64 (2019) ⁵	14.5 %	10.2 %	NR	30.2 %	14.3 %	NR	NR
Self-assessed health status (age-adjusted) proportion with fair or poor health (2017) ⁶	10 %	8.2 %	8.2 %	12.0 %	13.4 %	14.2 %	15.2 % (two or more races)
Infant mortality per 1,000 livebirths (2018) ⁷	5.7	4.6	3.6	4.9	10.8	8.2	9.4 (Native Hawaiian or other PI)
Life expectancy (2017) ⁸	78.6	78.5	NR	81.8	74.9	NR	NR
Heart disease-related mortality; age-adjusted (2017) ⁹	165	168.9	85.4	114.1	208	115.8	NR
Diabetes-related mortality; age-adjusted mortality per 100,000 (2017) ⁹	21.5	18.8	16.4	25.5	38.7	34.4	NR
Serious psychological distress (2018) ¹⁰	3.9 %	3.9 %	2.1 %	4.6 %	3.8 %	4.5 %	7.4 % two or more races)
Lifetime risk for men and boys of killed by police, per 100,000 (2018) ¹¹	52	39	9-23	53	96	36-81	

NR = not reported

*542 comprised of the following groups as defined in report: 313 (Other) + 95 (Arab) + 134 (Mixed group of people of multiple races)

1 USA Facts <https://usafacts.org/data/topics/people-society/population-and-demographics/population-data/population/>

2 <https://www.federalreserve.gov/econres/scfindex.htm>

3 US Bureau of Labor Force Statistics <https://www.bls.gov/webapps/legacy/cpsatab1.htm>

4 US Census Bureau <https://www2.census.gov/programs-surveys/demo/tables/health-insurance/time-series/hic/>

5 CDC <https://www.cdc.gov/nchs/products/databriefs/db382.htm>

6 CDC <https://www.cdc.gov/nchs/data/abus/2018/016.pdf>

7 CDC <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm>

8 USA Facts https://usafacts.org/articles/health-by-race-asthma-obesity-vaccination-life-expectancy-black-hispanic-white/?utm_source=bing&utm_medium=cp-c&utm_campaign=ND-Race&msclkid=7d70c682d443160cf70e993d3c35dfe7

9 CDC <https://www.cdc.gov/nchs/data/abus/2018/005.pdf>

10 CDC https://ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2018_SHS_Table_A-8.pdf

11 Edwards, Lee, Esposito, (2019). Risk of being killed by police force in the United States by age, race-ethnicity, and sex. <https://www.pnas.org/content/116/34/16793>

Appendix #12: Strategic plan development process

How was the strategic plan developed?

AMA Center for Health Equity staff led the first phase of development resulting in a health equity roadmap draft advancing toward an eventual strategic plan for 2020-26. This phase of development was led by initial observation and assessment of the AMA's existing priorities and structures, including its strengths. The draft roadmap included the following key elements to describe the AMA Center for Health Equity's work:

- Vision, mission, and guiding principles
- Theory of Change for embedding equity
- Strategic approaches
- Long-term goals
- Short-term priorities

To inform this strategic planning process, the AMA Center for Health Equity sought feedback from critical internal and external stakeholders to provide perspectives on the draft roadmap itself and on current and future opportunities for the AMA to 'move the needle' on health equity nationally. Internal feedback was gained through small focus groups of key AMA staff; external feedback was gained through an external consultant conducting fourteen (14) interviews of external stakeholders identified by AMA Center for Health Equity staff.

The themes below are gleaned from synthesizing data across focus group participants / interviewees. These themes served as the foundation for the AMA Center for Health Equity staff to come together virtually in July of 2020 over two days to consider visions for 2026, plans for 2023, and key priorities for 2020-21. Additionally, given the current contextual realities of the COVID-19 pandemic and the racial uprising and reckoning in the United States and beyond, these focus groups and interviews allowed AMA Center for Health Equity staff to hear from stakeholders directly impacted by these as to how those realities need to shift and inform the work of the AMA Center for Health Equity, and also require this planning to make room for the space to be as nimble and flexible as possible as they play out over time.

Internal Insights:

- Strategy: Because there are many diverse and varied approaches to health equity, the AMA Center for Health Equity must make strategic choices about how and where to invest energy and time. To make these choices, this process of understanding where the opportunities that have the most leverage is critical.
- Embedding: The AMA must embed equity into all Business Unit (BU) goals and objectives to resist equity becoming 'silo-ed' within the AMA Center for Health Equity rather than resting on the commitment and progress across the AMA: Management, Membership, and Medicine.
- Accelerator: The AMA must visualize health equity work as a vehicle to boost all strategic arcs as well as its core mission of improving the nation's health.

External Insights:

- Urgency: Within the context of a global pandemic disproportionately impacting Black, Brown and Indigenous populations in the United States, and a racial uprising and reckoning spurred by the death of George Floyd at the hands of Minneapolis police officers (and many other deaths of Black people due to white supremacy and police brutality), interviewees lifted an extreme sense of urgency for the weight and heft of the AMA to advance health equity in the United States (U.S.).
- Integrity: Interviewees reported that the combination of the perception of the integrity of the AMA itself, alongside the hiring of Aletha Maybank, MD, MPH, as the Center's leader is a unique combination of perceived integrity within both the medical and health equity field.

- **Waiting and seeing to deep suspicion:** As one interviewee succinctly stated, ‘the National Medical Association was formed in 1895 due to Black physicians being excluded from the AMA; the AMA offered a formal apology in 2008—that’s over 100 years in the waiting.’ While many interviewees reported viewing the AMA’s establishment of the Center as a quite positive move, there was also ubiquitous ‘weariness’ and ‘healthy questioning’ of this establishment. It remains to be seen if this is simply a gesture intended to be a symbol of a commitment to health equity or if the Center will be truly empowered and emboldened to do this critical work supported by the full weight and heft of the AMA.
- **Relevance:** While the AMA is perceived as an institutional powerhouse, interviewees also questioned its continued relevance to its membership, as older physicians retire and newer and younger physicians may opt not to join for numerous reasons including AMA’s racist history.

Acknowledgements

“Profound changes in the way we think and act must take place if we are to create a loving culture.”

—bell hooks, distinguished professor, feminist, and teacher on issues of social class, race and gender, *all about love*⁸²

This section extends our deep gratitude to the following people and organizations for their contributions to the development of the plan. In addition, we genuinely appreciate Shannon Sullivan of Groundswell Alliance for her guidance in the creation of plan.

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We recognize that health equity work is extensive and collaborative—that we follow in the footsteps of countless individuals and groups who have dedicated their lives to the issue of equity for decades, generations even. We value your efforts and conviction. We look forward to our continued collaboration.

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