AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 2
(I-20)

Introduced by: Caitlin Farrell DO, MPH

Subject: Denouncing Racial Essentialism in Medicine

Referred to: Reference Committee

Whereas, At the turn of the twentieth century, sociologist and civil rights leader W.E.B. DuBois synthesized sociological and scientific evidence to conclude that race is not a scientific category, and rather that racial health disparities stemmed from social, not biological, inequalities[1]; and

Whereas, "Racial essentialism" is defined as the belief in a genetic or biological essence that defines all members of a racial category[2–4]; and

Whereas, The modern scientific consensus is that race is a social construct based on prevailing societal perceptions of physical characteristics, and that there are no underlying biological traits that unite people of the same racial category[3–15]; and

Whereas, Race as a variable has been inconsistently defined in research literature, clinical practice guidelines, and even U.S. Census categorizations[5,8,12–14,16–22]; and

Whereas, Race is often inappropriately conflated with ethnicity, which led to passage of AMA policy recognizing that race and ethnicity are conceptually distinct (H-460.924)[8,15,16,23]; and

Whereas, Decades of rigorous genetics research has confirmed that genetic and biological variation exists within and among populations across the planet, and groups of individuals can be differentiated by patterns of similarity and difference, but these patterns do not align with socially-defined racial groups (e.g., white, Black) or continentally-defined geographic ancestral clusters (e.g., Africans, Asians, and Europeans)[4,5,7–11,13,16,23]; and

Whereas, Many clinical calculations that "correct for race" were developed under the mistaken belief that race is a useful proxy for intrinsic biological or genetic traits[11,13,14];and

Whereas, Spirometric pulmonary function tests (PFTs) guidelines currently recommending a race-based correction factor despite a 2013 literature review demonstrating that 94% of articles comparing PFTs between white and non-white groups do not assess confounders like socioeconomic status[14,17,18,24]; and

Whereas, Current literature demonstrates that use of race in clinical score calculators is unnecessary, less precise than biological measures, and leads to results that are not reproducible, as evidenced by the use of race in the calculation of estimated glomerular

filtration rate (eGFR) based on a 1999 study of 1,628 patients (only 12% of whom self-identified as “Black”)[14,19–21,25,26]; and

Whereas, Because the use of race in clinical algorithms reifies racial essentialism and can disproportionately harm Black patients, leading institutions around the country have discarded race-based reporting of eGFR and key stakeholders in the nephrology field are actively working to eliminate this practice in lieu of non-race-based alternatives[13,19–21,27–31]; and

Whereas, Clinical tests and criteria that use race-based factors often do not account for the existence of people from multiracial backgrounds, a population that now makes up 14% of infants born in the US, and other underserved populations including American Indians and Alaskan Natives[13,22,32]; and

Whereas, Current AMA policy supports “research into the use of methodologies that allow for multiple racial and ethnic self-designations” and encourages applying research evidence on race, ethnicity, and health to “the planning and evaluation of health services” (H-460.924); and

Whereas, Perpetuating the incorrect belief that race by itself can explain biological variation contributes to tangible inequities, such as the undertreatment of pain due to wrongly perceived biological differences in pain tolerance, delays in referral for renal transplantation, under-referral for DEXA scans, industry denial of worker’s compensation, and more[11,13,14,21,33–36]; and

Whereas, Although racial essentialism is harmful and has no scientific validity, teaching trainees about and researching race as a sociopolitical construct is useful to understand structural racism as a root cause of health inequity, the lived experiences of patients which contribute to their relationship with the healthcare system, and the day-to-day experiences which affect individual health outcomes[3,10–12,37–42]; and

Whereas, Since race and racism impact multiple structural and social determinants of health, there is no easy replacement risk factor, which highlights the need for directed research to uncover the true causal pathways mitigating racial differences in disease prevalence and health outcomes[10,11,20,21,23,40–43]; and

Whereas, Our AMA denounces practices which exacerbate health disparities, serves as a leading voice for marginalized minority groups, and “encourages investigators to recognize the limitations of current methods for classifying race” (H-65.963, H-460.924), but current policy does not identify or explicitly discourage the inappropriate practice of using race as a proxy for biological risk factors; and

Whereas, Our AMA-MSS recognizes that structural racism and systemic discrimination are distinct from interpersonal discrimination and implicit bias (295.194MSS); and

Whereas, Our AMA-MSS will be bringing a resolution to the A-20 House of Delegates that asks the AMA to identify current best practices that recognize and address the health effects of racism (350.025MSS), which notably could include explicitly addressing racial essentialism in medical education and clinical practice; and

Whereas, At the Special Meeting of the AMA House of Delegates in June 2020, our AMA Board of Trustees publicly recognized racism as an urgent threat to public health and resolved to "actively work to dismantle racist and discriminatory policies and practices across all of health care"[44]; and

Whereas, In September of 2020, the U.S. House Ways & Means Committee released a series of letters which called upon medical societies, including the AMA, to "describe how racism has influenced the use of race in medicine, science, and research, and call for a new path forward where medicine considers race as a tool to measure racism, not biological differences"letter[45]; therefore be it

RESOLVED, That our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities; and be it further

RESOLVED, That our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics; and be it further

RESOLVED, That our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME, other appropriate stakeholder organizations, and content experts to identify and address aspects of medical education and board examinations which may be perpetuating the mistaken belief that race is an inherent biologic risk factor for diseases; and be it further

RESOLVED, That our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors; and be it further

RESOLVED, That this resolution be immediately forwarded to the 2020 House of Delegates Special Meeting.

Fiscal note:

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RELEVANT AMA POLICY:

Race and Ethnicity as Variables in Medical Research H-460.924
Our AMA policy is that:
(1) race and ethnicity are valuable research variables when used and interpreted appropriately;
(2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations;
(3) physicians recognize that race and ethnicity are conceptually distinct;
(4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants;
(5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected;
(6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and
(7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.
CSA Rep. 11, A-98; Appended: Res. 509, A-01; Reaffirmed: CSAPH Rep. 1, A-11

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984
Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.
BOT Action in response to referred for decision Res. 602, I-15

Racial and Ethnic Disparities in Health Care H-350.974
1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. 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; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.
C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities
3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.
4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about

managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.
CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

Reducing Racial and Ethnic Disparities in Health Care D-350.995
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:
(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.
BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data H-350.953
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 healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool.
Res. 405, A-18

Guiding Principles for Eliminating Racial and Ethic Health Care Disparities D-350.991
Our AMA: (1) in collaboration with the National Medical Association and the National Hispanic Medical Association, will distribute the Guiding Principles document of the Commission to End Health Care Disparities to all members of the federation and encourage them to adopt and use these principles when addressing policies focused on racial and ethnic health care disparities; (2) shall 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; (3) urges medical societies that are not yet members of the Commission to End Health Care Disparities to join the Commission, and (4) strongly encourages all medical societies to form a Standing Committee to Eliminate Health Care Disparities.
Res. 409, A-09; Appended: Res. 416, A-11

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955
Our AMA:
1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.

4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.
Res. 406, A-16; Modified: BOT Rep. 28, A-18

AMA Initiatives Regarding Minorities H-350.971
The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components:
(1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine;
(2) Increased awareness and representation of minority physician perspectives in the Association's policy development, advocacy, and scientific activities;
(3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities;
(4) Response to inquiries and concerns of minority physicians and medical students; and
(5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.
CLRPD Rep. 3, I-98; CLRPD Rep. 1, A-08

Establishment of State Commission / Task Force to Eliminate Racial and Ethnic Health Care Disparities H-440.869
Our AMA will encourage and assist state and local medical societies to advocate for creation of statewide commissions to eliminate health disparities in each state.
Res. 914, I-07; Modified: BOT Rep. 22, A-17

Discriminatory Policies that Create Inequities in Health Care H-65.963
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.
Res. 001, A-18

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to

the President of the United States.
CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17