

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS*

CEJA Report 04-A-23

Subject: Responsibilities to Promote Equitable Care

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 The disproportionate impact of the COVID-19 pandemic on minoritized and marginalized
2 communities harshly illuminated ongoing inequities in health care across the globe. In the U.S., the
3 pandemic lent new energy to calls for change within and outside medicine and health care. Even as
4 the American Medical Association (AMA) drew on the *Code of Medical Ethics* as a key resource
5 during this public health crisis, the Council on Ethical and Judicial Affairs recognized that
6 additional guidance is needed to explicitly address the ethical implications of social forces that
7 drive how and to whom health care is provided. What role, that is, should physicians and health
8 care institutions play as agents for change in the face of manifest inequity?
9

10 Looking critically at the *Code*, the council observed that existing guidance does indeed speak to
11 matters of fairness or justice in health care. [Principle IX](#) of the *AMA Principles of Medical Ethics*
12 enjoins physicians to “support access to care for all people.” Opinions variously enjoin physicians
13 to promote access to care and address financial barriers to care; to avoid discriminating against or
14 exploiting patients and research participants; to be prudent stewards of health care resources in the
15 interests of all; to ensure that limited resources are allocated solely on the basis of medical criteria;
16 even to ensure that organs and tissues for transplantation are treated as a national rather than a
17 regional or local resource. (Appendix A.)
18

19 At the same time, the council recognized that, for the most part, guidance in the *Code* focuses
20 narrowly on the conduct of individual physicians in their interactions with individual patients. By
21 presenting guidance that addresses the manifestations of inequitable care, not the root causes, the
22 *Code* tacitly presumes that inequity flows straightforward from the decisions and actions of
23 individuals. Yet medicine has long understood that social factors play a critical role in health status
24 and health disparities.
25

26 Such an individualist approach further fails to realize that the social drivers of health have deep and
27 powerful histories. While important and necessary, it is not sufficient to remind physicians of their
28 professional ethical obligations not to discriminate against patients based on explicit and
29 continuously evolving “protected categories” of civil rights law. A professional responsibility to
30 promote equitable care calls for situated, historically informed social and political knowledge of a
31 sort that physicians are not specifically trained in, however, and on forms of discernment and self-
32 reflection on which ethics guidance is generally silent.

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1 This report by the Council on Ethical and Judicial Affairs seeks to explore more thoughtfully the
2 joint responsibilities that physicians as individual professionals and health care institutions as sites
3 of service have to ensure that all patients in their practices and communities receive “safe,
4 effective, patient centered, timely, efficient, and equitable care.”[\[Opinion 1.1.6\]](#)

5 6 FOUNDATIONAL ETHICS

7
8 At its core, the *Code* rests on an understanding of medicine as inherently a moral activity, rooted in
9 the encounter between “someone who is ill, on the one hand, and someone who professes to heal,
10 on the other,” in the words of physician and ethicist Edmund Pellegrino [1]. The “covenant of
11 trust” established in such encounters binds physicians in a duty of fidelity to patients. The *Code*
12 enjoins physicians, as medical professionals, to “dedicate themselves to providing competent
13 medical care and respect for human dignity and rights.”[\[Principle I\]](#) Doing so encompasses a
14 responsibility for physicians to “examine their own practices to ensure that inappropriate
15 considerations about race, gender identity, sexual orientation, sociodemographic factors, or other
16 nonclinical factors, do not affect their judgment.”[\[Opinion 8.5\]](#) Competent physicians “cultivate
17 continuous self-awareness and self-observation,” and strive to “be attentive to environmental and
18 other factors that may compromise their ability to bring appropriate skills to the care of individual
19 patients and act in the patient’s best interest.”[\[Opinion 8.13\]](#)

20
21 Together these commitments entail physicians’ responsibility to become attentive to how their own
22 perceptions, attitudes, and assumptions can color how they interact with different patients and to
23 take steps to ensure that in delivering care their behavior as individuals neither privileges some
24 patients nor disadvantages others.

25
26 It is also the case that “clinical medicine is the final pathway through which public policies
27 ultimately come to affect the lives of sick persons” [2]. Although Pellegrino had in mind the
28 specific example of managed care as the public policy in question, his observation holds more
29 broadly. Physicians’ duty of fidelity also encompasses the responsibility to recognize and address
30 the ways in which the policies and practices of health care institutions shape patients’ experience of
31 health, illness, and care.

32 33 SHIFTING PERSPECTIVE: FROM “CULTURAL COMPETENCE” TO “STRUCTURAL 34 COMPETENCE”

35
36 Training physicians for “cultural competence” has been promoted as a way to ensure that
37 physicians take account of non-medical dimensions of health and illness, with the ultimate goal of
38 promoting robust respect for patient autonomy and improving quality of care. By learning how to
39 recognize “cross-cultural expressions of illness and health,” the thinking has been, physicians
40 would “be able to counteract the marginalization of patients by race, ethnicity, social class,
41 religion, sexual orientation or other markers of difference” [3]. Yet as the physician anthropologist
42 Arthur Kleinman noted, “culture” is not reducible to a technical skill in which clinicians can
43 develop expertise [4]. Moreover, “cultural factors are not always central to a case, and might
44 actually hinder a more practical understanding of an episode [of illness].”

45
46 Patients’ health status, outcomes, and experiences of care are shaped significantly by social,
47 economic, and political drivers unrelated to cultural understandings of illness and healing [3,5]. To
48 make meaningful progress in achieving equitable care, physicians must recognize how “the
49 pathologies of social systems impact the material realities of their patients’ lives” [3]. As the
50 pathologist Rudolf Virchow noted more than a century ago, “If medicine is to fulfill her great task,

1 then she must enter the political and social life. Do we not always find the diseases of the populace
 2 traceable to defects in society” [5]?

3 Truly to address their patients’ health needs, physicians must acquire skills, not of cultural
 4 competence, but of “structural competence.” That is:

5
 6 the trained ability to discern how a host of issues defined clinically as symptoms, attitudes,
 7 or diseases (e.g., depression, hypertension, obesity, smoking, medication “noncompliance,”
 8 trauma, psychosis) also represent downstream implications of a number of upstream
 9 decisions, about matters such as health care and food delivery systems, zoning laws, urban
 10 and rural infrastructures, medicalization, or even about the very definitions of health and
 11 illness [3,6].

12
 13 ADDRESSING INEQUITY, PROMOTING EQUITABLE CARE¹

14
 15 Public health expert Camara Jones observed that when people think about “racism” they think of
 16 “personally mediated racism”: the expression of prejudice and discrimination based on “differential
 17 assumptions about the abilities, motives, and intentions of others” and “differential actions toward
 18 others according to their race” [7]. Personally mediated racism may be intentional or unintentional,
 19 manifest in acts of commission and acts of omission. Jones distinguishes this from “institutional
 20 racism,” that is, “differential access to goods, services, and opportunities of society by race.”
 21 Institutionalized racism, she notes, is structural, “codified in our institutions of custom, practice,
 22 and law, so there need not be an identifiable perpetrator.”

23
 24 Fulfilling the ethical responsibility to promote equitable care, then, requires that medicine address
 25 inequity and discrimination not only at the level of personal interactions among physicians and
 26 patients, but equally at the institutional level in the policies and practices that structure interactions
 27 within an institution’s walls and in the institution’s interactions with the community (communities)
 28 beyond its walls.

29
 30 *Personal Interactions*

31
 32 Physicians individually cannot be expected to repair structural discrimination and inequity in health
 33 care on their own, but they *can* hold themselves accountable for the ways in which their own
 34 interactions with patients, families, and fellow health care personnel may contribute to perpetuating
 35 discrimination and inequity. Doing so requires that physicians cultivate awareness of how they
 36 perceive others, how they speak about or describe persons and medical conditions, and how they
 37 approach interactions with patients and others one on one. As first steps, they must address in their
 38 own behaviors and implicit biases, such as the use of stigmatizing language and habits of
 39 discrediting patients’ knowledge and reports of illness. So too, adopting a trauma-informed care
 40 approach can help physicians recognize and address the medical and psychosocial effects for
 41 patients of persistent marginalization and discrimination.

42
 43 *Implicit bias.* In its 2003 report, *Unequal Treatment*, the Institute of Medicine linked health care
 44 professionals’ implicit bias—that is, bias, prejudices, and stereotypes that are not consciously held
 45 or recognized—to health disparities [8]. Subsequent research has confirmed that in health care, bias
 46 is “negatively associated with both care satisfaction and provider trust among racial/ethnic minority
 47 patients” [9]. Among African American patients, for example, physicians’ implicit bias has been

¹ See Appendix B for selected resources for individuals and institutions.

1 shown to be a “relatively consistent predictor of ethnic/racial differences in patients’ subjective
2 experiences with their health care providers” [10].

3
4 Whether implicit bias is straightforwardly linked to discriminatory behavior is open to question
5 [10], but learning to recognize one’s own biases offers a point of entry for cultivating the
6 awareness and critical self-reflection required of physicians as medical professionals. The most
7 effective training will affirm learners’ egalitarian goals and commitment and go beyond raising
8 awareness to teach how to control implicit bias, using active learning techniques that enable
9 learners to practice new skills [10]. Training to “replace negative nonverbal or paraverbal behaviors
10 with positive communication behaviors” can be a practical, attainable way to improve health
11 outcomes [11].

12
13 *Stigmatizing language.* How physicians and other health care personnel speak to and about patients
14 conveys multiple messages, intended and otherwise. Languages that “others” patients, “blames”
15 them for their illness, or casts them as dangerous or threatening can influence care in the moment
16 and risks perpetuating bias by inscribing it in the medical record [12,13]. Thus the U.S. National
17 Institute on Drug Abuse, for example, offers preferred language for talking about addiction [14];
18 Diabetes Australia likewise draws attention to problematic language used about diabetes [15].
19 Phrasing that suggests negative attitudes toward patients, questions patients’ credibility, conveys
20 disapproval of patients, or stereotypes them by race or social class captured in the medical record
21 can undermine care [13]. By the same token, complimenting patients, offering patient-centered
22 accounts of health behaviors that minimizes blame, and incorporating into the record details that
23 personalize the patient as an individual can foster less discriminatory, more effective interactions
24 [13].

25
26 Language that calls into question patients’ credibility or their ability to report their experience of
27 illness accurately or appropriately constitutes a form of *epistemic injustice* [16]. It demeans patients
28 as knowers based on physicians’ expectations, explicit or implicit, about what information is
29 relevant and meaningful for the health care encounter. It privileges a biomedical model of disease
30 over patients’ culturally and socially informed explanatory models and lived experience of illness
31 [4], at times in ways that may actually be harmful to patients when marginalizing their reports of
32 illness undermine diagnostic accuracy, isolate patients, or even lead them to withdraw from care
33 [17]. Epistemic injustice may be both more common and more likely to be harmful for patients
34 whose conditions are poorly understood or contested biomedically—as has been the case with
35 chronic fatigue syndrome, for example [17]. By minimizing or outright dismissing the patient’s
36 contribution to the encounter, physicians undermine trust and the opportunity to create an effective
37 therapeutic relationship.

38
39 *Trauma-informed practice.* Adopting a trauma-informed approach to care offers further
40 opportunity for physicians and other health care professionals to promote equitable care. Trauma-
41 informed care recognizes that trauma “has lasting adverse effects on the individual’s functioning
42 and mental, physical, social, emotional, or spiritual well-being” [18]. “Trauma” encompasses more
43 than the effects of a specific event—sexual abuse, interpersonal violence, or exposure to combat,
44 for example [19]. It also acknowledges the impact of social, economic, and political structures that
45 cause harm to individuals and communities captured in Paul Farmer’s concept of “structural
46 violence” [20], which can carry forward through descendants of those who suffered [E.g., 21,22].

47
48 Suggestions for implementing trauma-informed care focus on patient-centered communication
49 practices, understanding the effects of trauma, interprofessional collaboration, understanding how
50 one’s own experience of trauma may influence interactions with patients, and specific screening for

1 trauma [19]. Trauma-informed practice acknowledges that physicians cannot change a patient’s
2 past; rather, it offers a way to help improve patients’ function and well-being in the present [23].

3
4 *Institutional Policies and Practices*

5
6 Health care institutions share in medicine’s fundamental commitment of fidelity to patients.
7 Institutions are the physical and social settings of medical practice, constellations of resources and
8 relationships established to enable the provision of care. Indeed, health care only happens in and
9 through institutions. They reflect the attitudes of clinical professionals, administrators, and society
10 even as they help to form the attitudes of practitioners and shape the delivery of care. In
11 contemporary health care, institutions are the primary medium by which health care interacts with
12 the political, economic, and social structures of society and the major means by which care is
13 delivered. They too bear the ethical responsibilities of medicine.

14
15 The policies and practices of health care institutions importantly determine what care choices are
16 available to patients and physicians. Regardless of size, physician practices, hospitals, and other
17 institutions share responsibility to promote equitable access and care for all. What an institution
18 chooses to know about its patients and staff and how that information factors into institutional
19 decision making and patterns of practice can play a significant role in whether or to what extent the
20 institution promotes equitable care across the board.

21
22 *Social drivers of health.* Just as how physicians perceive, speak about, and interact with others can
23 perpetuate discriminatory attitudes and inequity, so too can organizational decisions about what
24 information the institution captures about the patients it serves, how it does so, how that
25 information is available to clinicians for treatment purposes, and how (or whether) it informs
26 institutional operations. The foundational “explanatory model” of allopathic medicine—to borrow
27 Kleinman’s terminology again—grounds diagnosis and treatment jointly in biological function and
28 personal health behaviors, despite ample evidence that social factors powerfully influence health
29 and the delivery of health care [3,20,24].

30
31 Recognition of the significant health impact of structural factors has led to calls to rethink the
32 social history to capture information beyond questions about tobacco or alcohol use to glean
33 information about the socioeconomic and political realities of patients’ lives.[25]. For example,
34 initiatives at Brigham & Women’s Health and Massachusetts General Hospital have expanded
35 history taking to gather information about patients’ particular life circumstances, emotional health,
36 perceptions of health care, and health-related behaviors, as well as access to and utilization of
37 health care [26]. Other institutions have deployed tools to assess patients’ “structural
38 vulnerability,” including whether someone has money to pay for rent, food, and utilities; a safe,
39 stable place to sleep; friends, family, or others who can provide help when needed; or has
40 experienced discrimination [27,28].

41
42 Some health care institutions have gone beyond collecting data to intervene directly to address the
43 extra-medical factors that so deeply affect health through initiatives to promote income security,
44 medical-legal partnerships to help patients address legal issues that impinge on health status, and
45 clinic-based child literacy programs among others [29,30].

46
47 *Race-based versus race-conscious tools.* As CEJA noted in its 2021 [informational report](#) on
48 augmented intelligence in medicine, scholars have argued compellingly that medicine in the U.S.
49 helps to perpetuate racial discrimination and inequity—and provide inadequate clinical care—when
50 it grounds research and clinical practice in notions of race as unproblematically a genetic,
51 biological characteristic of patients rather than a socially mediated classification of persons [31,32].

1 A growing body of evidence demonstrates that race-adjusted practices, intended to improve care,
2 are often in fact harmful [32], particularly as a result of biases built into clinical algorithms and
3 machine learning tools intended to support prediction of risk or diagnosis [33,34].
4

5 Nonetheless, ignoring race and ethnicity entirely can also be damaging. As imperfect as the
6 category of race (/ethnicity) is, as a proxy measure it does indirectly capture important information
7 about the influence of sociocultural, economic, environmental and genetic factors on health and
8 health outcomes [31]. Scholars urge scientists and clinicians to continue to use categories of race
9 and ethnicity until better predictors become available [31]. Ensuring that when racial categories are
10 used, they promote equitable health remains of the utmost importance, however.
11

12 *Aversive racism.* How institutions interact with and treat their staff and affiliated personnel can also
13 perpetuate discrimination and inequitable care—e.g., policies and practices for hiring and
14 promoting personnel can reflect aversive racism, “which results from the interplay of . . . social
15 dominance, implicit bias, and in-group favoritism” [35]. Aversive racism is reflected in laments
16 about lack of qualified candidates from historically minoritized communities; it attributes an
17 individual’s inability to thrive within an organization to their personal characteristics or behaviors;
18 and it buys into the “myth of meritocracy” that sees success as a function of ability while ignoring
19 the effects that structural inequity has on opportunity. To the extent that racial, ethnic, or gender
20 concordance between patient and physician improves patient satisfaction with care and health
21 outcomes, fostering and respecting diversity among health care personnel can be a path toward
22 promoting more equitable care.
23

24 *Equity, safety, and quality improvement.* As a species of “wicked problem,” a term first introduced
25 in the realm of urban planning [36], inequitable care doesn’t lend itself to a simple, one-time
26 solution. Wicked problems are dynamic, highly complex, and resistant to solution; generally there
27 is “significant disagreement [among stakeholders] about the nature and cause of the problem and . . .
28 . potential solutions” [37]. By their nature, wicked problems cannot be solved by individual action
29 but must be addressed at the organizational or systems level. To address ongoing inequities in care,
30 institutions must first acknowledge that such inequities exist—they must ensure that they have
31 compendious information about patients and leverage that information to understand where and
32 how change needs to be made. For example, studies show that African American patients with
33 heart failure tend to have poorer outcomes than white patients—but *why* that is the case isn’t
34 apparent without further exploration. A retrospective study at Brigham & Women’s Health found
35 that patients who receive care in a cardiology unit rather than on a medical ward have better
36 outcomes, and that African American and Latinx patients were less frequently admitted to
37 cardiology from the emergency department, as were women, suggesting an institutional pattern that
38 may contribute to disparate outcomes [38].
39

40 Health care institutions in fact already have models on hand that can be adapted to promote
41 equitable care in the form, especially, of patient safety initiatives [39]. Like patient safety, equity
42 initiatives can focus on redesigning the processes and systems that perpetuate discrimination and
43 inequity. In both realms, well-designed initiatives:
44

45 balance [a] systems approach with individual accountability. Both recognize the role of
46 cognitive, often subconscious biases in contributing to unintentional harm. Both highlight
47 the importance of psychological safety to support difficult conversations. And both avoid
48 excessive focus on individual or interpersonal blame. The goal isn’t to shame individual
49 clinicians but to build resilient systems around them that support optimal behaviors [39].

1 ADVOCATING FOR CHANGE

2
3 For both individual health care professionals and for health care institutions, the commitment to
4 serve patients in need entails obligations to examine prevailing attitudes, habits, policies, and
5 practices that determine what care is available to whom and to take steps to remove or re-engineer
6 obstacles that undermine the ability to ensure equitable care for all.

7
8 Physicians have a responsibility to recognize that despite ongoing change in health care and
9 seeming erosion of their authority they *do* have power within their institutions, and to use their
10 voice and status to advocate for change. They have a responsibility to help create opportunities in
11 which to raise challenging issues, to argue for tools to enable difficult conversations, and to
12 develop relationships within their institutions to support one another. Ultimately, physicians have a
13 responsibility to thoughtfully and constructively identify and begin to address the formal and
14 informal expectations that create barriers to equitable care for their patients and equitable treatment
15 of those who provide care and support caregiving within the health care institution.
16 Health care institutions have a responsibility to foster change within their walls, and to
17 acknowledge the multiple roles they play in their communities. Health care institutions are deeply
18 embedded in the life of their communities beyond their role in delivering care—they are
19 employers, purchasers of goods and services, property owners, and civic leadership. A growing
20 number of institutions recognize that as “anchor institutions” within their communities they can—
21 and should—be agents for positive change. As member institutions of the Healthcare Anchor
22 Network observe,

23
24 Hospitals and health systems are critical local economic engines and mission-driven
25 organizations inextricably linked to the long-term well-being of those we serve—because
26 of this, we as healthcare leaders, are uniquely positioned and incentivized to play a more
27 active role in supporting our local economies. We have an opportunity and obligation to
28 improve health and well-being outcomes in the communities we serve and confront
29 economic and social instability in our nation that remain obstacles to that goal [40].
30

31 The Institute for Healthcare Improvement’s Pursuing Equity Initiative identifies five strategies
32 institutions should adopt to eliminate racism—and other forms of discrimination—in health care:

- 33
- 34 • Understanding the context of racism and other forms of oppression among the
 - 35 communities in which the institution is located;
 - 36 • Normalizing discussion of oppression and listening to stakeholders to understand their
 - 37 experience;
 - 38 • Meaningfully promoting workforce diversity;
 - 39 • Developing and implementing business practices and policies through an equity lens;
 - 40 • Adopting data systems that identify and track equity gaps in clinical outcomes;
 - 41 • Using quality improvement strategies to narrow equity gaps and improve health care
 - 42 for all [41].
- 43

44 RECOMMENDATION

45
46 In light of these considerations, the Council on Ethical and Judicial Affairs recommends that the
47 following be adopted and the remainder of this report be filed:

48
49 Medicine at its core is a moral activity rooted in the encounter between a patient who is ill and
50 a physician who professes to heal. The “covenant of trust” established in that encounter binds
51 physicians in a duty of fidelity to patients. As witness to how public policies ultimately affect

1 the lives of sick persons, physicians' duty of fidelity also encompasses a responsibility to
2 recognize and address how the policies and practices of the institutions within which
3 physicians work shape patients' experience of health, illness, and care. As the physical and
4 social settings of medical practice, hospitals and other health care institutions share the duty of
5 fidelity and, with physicians, have a responsibility to ensure that the care patients receive is
6 safe, effective, patient centered, timely, efficient, and equitable.

7
8 Enduring health disparities across patient populations challenge these duties of fidelity.
9 Disparities reflect the habits and practices of individual clinicians and the policies and
10 decisions of individual health care institutions, as well as deeply embedded, historically rooted
11 socioeconomic and political dynamics. Neither individual physicians nor health care
12 institutions can entirely resolve the problems of discrimination and inequity that underlie health
13 disparities, but they can and must accept responsibility to be agents for change.

14
15 In their individual practice, physicians have an ethical responsibility to address barriers to
16 equitable care that arise in their interactions with patients and staff. They should:

- 17
18 a) Cultivate self-awareness and strategies for change, for example, by taking advantage of
19 training and other resources to recognize and address implicit bias;
20 b) Recognize and avoid using language that stigmatizes or demeans patients in face-to-
21 face interactions and entries in the medical record;
22 c) Use the social history to capture information about non-medical factors that affect a
23 patient's health status and access to care to inform their relationships with patients and
24 the care they provide.

25
26 Within their institutions, as professionals with unique knowledge, skill, experience, and status,
27 physicians should collaborate with colleagues to promote change. They should:

- 28
29 d) Support one another in creating opportunities for critical reflection across the
30 institution;
31 e) Identify institutional policies and practices that perpetuate or create barriers to
32 equitable care;
33 f) Participate in designing and supporting well-considered strategies for change to ensure
34 equitable care for all.

35
36 As institutions in and through which health care occurs, hospitals and other health care
37 institutions share medicine's core values and commitment of fidelity, and with it ethical
38 responsibility to promote equitable care for all. Moreover, as entities that occupy positions of
39 power and privilege within their communities, health care institutions are uniquely positioned
40 to be agents for change. They should:

- 41
42 g) Support efforts within the institution to identify and change institutional policies and
43 practices that may perpetuate or create barriers to equitable care;
44 h) Engage stakeholders to understand the histories of the communities they serve and
45 recognize local drivers of inequities in health and health care;
46 i) Identify opportunities and adopt strategies to leverage their status within the
47 community to minimize conditions of living that contribute to adverse health status.

48
49 (New HOD policy)

Fiscal Note: Less than \$500

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Appendix A
Existing Guidance on Justice

	Promote access/ address barriers to care	Do not discriminate	Do not exploit	Distribute benefits fairly	Distribute burdens fairly	Be prudent stewards of shared resources	Advocate for patients	Promote equitable care
Principle VII	X						X	
Principle IX	X							
1.1.2 Prospective patients		X				X		
1.1.6 Quality								X
1.1.7 Physician exercise of conscience		X						
1.1.8 Physician responsibilities for safe patient discharge		X				X	X	
6.2.1 Guidelines for organ transplantation from deceased donors	X	X				X		
6.2.2 Directed donation of organs for transplantation	X			X				
7.1.3 Study design and sampling		X			X			
7.3.2 Research on emergency medical interventions					X			
7.3.3 International research	X		X	X	X			
7.3.10 Expanded access to investigational therapies			x					
8.5 Disparities in health care	X	X		X				
8.11 Health promotion and disease prevention	X							
11.1.1 Defining basic health care	X		X		X		X	
11.1.2 Physician stewardship of health care resources	X						X	
11.1.3 Allocating limited health care resources			X		X	X		
11.1.4 Financial barriers to health care access	X							X
11.2.5 Retainer practices	X							
11.2.6 Mergers of secular and religiously affiliated health care institutions	X							X

APPENDIX B
SELECTED SAMPLE RESOURCES

Racial and Health Equity: Concrete STEPS for Smaller Practices

https://edhub.ama-assn.org/steps-forward/module/2782426?resultClick=1&bypassSolrId=J_2782426

National Institutes of Health – Implicit Bias Training Course

<https://diversity.nih.gov/sociocultural-factors/implicit-bias-training-course>

American Academy of Family Physicians – Implicit Bias Resources

<https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit/implicit-bias.html>

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National Institute on Drug Abuse – Words Matter

<https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction>

Temple Health – Reduce Stigmatizing Language in Healthcare

<https://www.templehealth.org/for-physicians/reduce-stigmatizing-language>

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Indiana University – Trauma-Informed Care Professional Development Certificate

<https://rural.indiana.edu/impact/health/trauma-informed-care-certificate.html>

Texas Department of Family and Protective Services – Trauma-Informed Care Training

https://www.dfps.texas.gov/Training/Trauma_Informed_Care/default.asp

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Centers for Medicare and Medicaid – Accountable Health Communities

Health-Related Social Needs Screening Tool

<https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>

American Academy of Family Physicians – Social Needs Screening Tool (Short Form)

https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf

Protocol for Responding to & Assessing Patients’ Assets, Risks & Experiences (PRAPARE)

<https://prapare.org/>

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Racial and Health Equity: Concrete STEPS for Health Systems

https://edhub.ama-assn.org/steps-forward/module/2788862?resultClick=1&bypassSolrId=J_2788862

AMA – Advancing Equity Through Quality and Safety Peer Network

<https://www.ama-assn.org/about/ama-center-health-equity/ama-advancing-equity-through-quality-and-safety-peer-network>

Anchor Mission Playbook – prepared by Rush University

<https://www.rush.edu/sites/default/files/2020-09/rush-anchor-mission-playbook-091117%282%29.pdf>

Institute for Healthcare Improvement – Pursuing Equity Learning and Action Network

<https://www.ihl.org/Engage/Initiatives/Pursuing-Equity/Pages/default.aspx>