May 18, 2021

TO: MSSNY Council

FROM: Joshua Cohen, MD
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SUBJECT: MSSNY Council Action Item on Racism and Intersectionality in Medicine

The Medical Society of the State of New York
Committee on Health Disparities

On April 23, 2021, the MSSNY Committee on Health Disparities met and discussed the introduction on a resolution on racism and intersectionality in medicine. At the meeting, there was discussion regarding a preliminary draft of a resolution with input from committee members. A robust discussion with the full committee continued via email and the result of this resolution is now before the MSSNY Council for its consideration:

Addressing Racism and Intersectionality in Medicine

Whereas, Underrepresented or marginalized racial and ethnic populations in the United States have shorter lifespans, greater physical and mental illness burden, earlier onset and more aggressive progression of disease, higher maternal and infant mortality, and less access to healthcare services[1-11]; and

Whereas, Systemic racism is defined as a structural and legalized system that results in differential access to goods and services, including health services[5,9,12,13]; and

Whereas, Cultural racism refers to negative and harmful racial stereotypes portrayed in culturally shared media and experiences[5,9,12,13]; and

Whereas, Interpersonal racism is implicit and explicit racial prejudice, including explicitly expressed racist beliefs and implicitly held racist attitudes and actions based upon or resulting from these prejudices[5,9,12,13,14], and

Whereas, Systemic racism results in segregation of marginalized, racialized groups to less financially supported neighborhoods, schools, and jobs, lower salary for the same work, lower rates of promotion despite similar performance and higher rates of incarceration and police violence, all of which contribute to health inequities and have been independently associated with worse health outcomes[5,9,13-24]; and

Whereas, Interpersonal racism has been independently associated with chronic pain, poorer sleep, lower likelihood of accessing preventive screenings or prenatal care, psychosocial distress, greater likelihood of alcohol use and smoking, and lower overall health[5,25-27,29-31]; and

Whereas, we recognize systemic racism, gender, ethnic, religious, disability and other discrimination exists in our society and within our medical community; and

Whereas, In healthcare, systemic and cultural racism and prejudice result in less access to care for minority groups and in different groups routinely receiving different treatment for the same complaints[9-10,13,33-35]; and

Whereas, In healthcare, systemic and cultural racism and prejudice result in less access to care for minority groups and in different groups routinely receiving different treatment for the same 28 complaints[9-10,13,33-35]; and

Whereas, When interpersonal racism and prejudice are committed by healthcare workers, it undermines the physician-patient relationship, harms patients' trust in the healthcare field as a whole, and makes patients less likely to seek needed care[9,12,26,27,34-40]; and

Whereas, Experiencing perceived racial discrimination and prejudice induces a chronic stress response causing heritable, intergenerational epigenetic changes, compounding disparities in health outcomes and chronic disease incidence that exist even when controlling for other socioecological factors[3,41-46]; and

Whereas, Rates of reported hate-based crimes and public expressions of discrimination and prejudice against racial and ethnic minorities have increased in recent years[30,47-54]; and

Whereas, Racism and prejudice implies decreased human value of the individual, which adversely affects patient engagement, and as a result contributes to significantly poor health outcomes particularly for African Americans, and the role of racism and prejudice in creating and perpetuating health disparities is frequently overlooked in research and healthcare literature and policy[5,13]; and

Whereas, Though developing technologies have potential to provide great improvement to health and well-being, they have also been shown to have an alarming capacity for absorbing, perpetuating, and compounding racism and prejudice in healthcare on a massive, industry-wide scale, making it clear that a proactive approach to prevent or identify and eliminate racism and prejudice in technologies as they are created is crucial[55-58]; and

Whereas, "Racial essentialism" is defined as the belief in a genetic or biological essence that defines all members of a racial category[59-61]; 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[60-72]; 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)[61,62,64-68,70,73,74]; and

Whereas, Demographic representation has been shown to improve health care access for underserved populations, improve the cultural effectiveness of the physician workforce as a whole, and improve medical research and innovation for all populations, yet there remains a shortage of underrepresented minorities in medical education and medical school faculty[75-78]; and

Whereas, People with disabilities comprise 22.2 percent of the US adult population, but less than 3 percent of medical students and less than 10 percent of practicing physicians; [79-80] and

Whereas, Though Title I of the Americans with Disabilities Act prohibits discrimination against people with disabilities and requires schools and employers provide reasonable accommodation for those with disabilities, yet the medical field has been slow to eliminate the barriers, including the lack of appropriate accommodations, that prohibit those with disabilities from entering the medical profession or continuing to practice [81-83]; and

Whereas, MSSNY seeks to partner with stakeholders to reduce and eliminate inequities in health and healthcare, medical education and training, the medical workforce, and organized medicine, was the writer of the policy that ultimately resulted in the development of the AMA Center for Health Equity, and has developed legislative and advocacy policies to address inequities as stated in its annual legislative document passed by MSSNY Council, which should be made permanent MSSNY policy passed by the MSSNY HOD; therefore be it

RESOLVED, that MSSNY affirms that racism is a public health crisis; and be it further

RESOLVED, that MSSNY will evaluate its mission statement to be clear that it supports equity in all aspects of its work, and be it further

RESOLVED, that MSSNY will systematically evaluate its policies and procedures to be clear that it supports equity in all aspects of its work, in both existing and in future policies and procedures, and that record of this process be visible to all members, and be it further

RESOLVED, that MSSNY encourage all county societies to affirm that racism is a public health crisis; and be it further

RESOLVED, that MSSNY work with all county medical societies to ensure that their mission statements are inclusive of the needs of underrepresented minority patients and physicians, and be it further

RESOLVED, that MSSNY encourage all county societies to systematically evaluate their policies and procedures to be clear that they support equity in all aspects of their work, in both existing and in future policies and procedures, and that records of this process be visible to all members, and be it further

RESOLVED, that MSSNY work collaboratively with all county medical societies to develop a strategic plan to improve recruitment, retention, support, and mentoring of members who are Black and Latinx, people of color (POC), indigenous people, Asian American and Pacific Islanders (AAPI), people with disabilities and/or sexual and gender minorities, and be it further

RESOLVED, that MSSNY work with medical schools in New York to ensure that underrepresented minority students are successfully recruited and supported to reinforce the pipeline of physicians and physician leaders to be representative of the population we serve, and be it further

RESOLVED, that MSSNY will seek that all medical schools in New York will utilize appropriate culturally relevant curricula that does not propagate race-based medicine, understanding that race is a social construct and not a biological one, and be it further

RESOLVED, that MSSNY, through its Committee to Eliminate Health Disparities, seeks to

- **increase awareness of how discrimination based on factors such as racism, classism, cisgenderism, heterosexism, ableism, patriarchy, and xenophobia contributes to both societal and health inequities and to ensure that all New Yorkers receive the best care possible and can achieve the best health possible**
- **work with the AMA, specialty societies, Albany leadership, community groups, and other stakeholders to eliminate inequities, particularly those inequities that adversely impact the health and well-being and access to and quality of care for persons who are from historically disadvantaged populations**
- **Prevent and manage diseases that are prevalent in historically disinvested populations burdened with the worse disease outcomes, including diabetes, hypertension, and cancer, through educational programming for physicians and other stakeholders;**
- **Reverse the troubling increases in race/ethnic-based health inequities such as maternal mortality; and**
- **Promote expanded funding for programs that attract a more diversified physician workforce, increasing the number of minority faculty including Black, Latinx, Native American, female, LGBTQ faculty, and faculty with disabilities teaching in medical schools and expanding medical school pipeline programs in rural and urban areas to address the shortage of physicians in medically underserved areas of New York State, and be it further**

RESOLVED, that MSSNY will request that *all* New York medical specialty organizations, medical schools, non-physician healthcare organizations and hospitals adopt similar resolutions

(FOR COUNCIL ACTION)

For reference, the section on health disparities from MSSNY legislative document is below. Also for reference, the entire legislative document has been forwarded as a PDF.

ELIMINATING HEALTH DISPARITIES

MSSNY's Committee to Eliminate Health Disparities seeks to increase awareness of how discrimination based on factors such as racism, classism, cisgenderism, heterosexism, patriarchy, and xenophobia contributes to both societal inequities and health disparities and to ensure that all New Yorkers receive the best care possible and can achieve the best health possible. MSSNY must be a voice for New York's most vulnerable populations, including sexual, gender, racial and ethnic minorities, who suffer from policies that are discriminatory and that further widen the gaps that exist in health and wellness in our nation. The significantly higher rates of infection, hospitalizations, and deaths due to COVID-19 seen in Black and Latinx New Yorkers have made visible the longstanding effects of systemic racism that have caused Black people in New York to have the worst health outcomes for many health conditions. To eliminate such disparities, we must work to eliminate the inequities that cause these disparities. Through this committee, MSSNY is seeking to:

- Work with the AMA, specialty societies, Albany leadership, community groups, and other stakeholders to eliminate inequities, particularly those inequities that adversely impact the health and well-being and access to and quality of care for persons who are from historically disadvantaged populations;
- Prevent and manage diseases that are prevalent in historically disinvested populations burdened with the worse disease outcomes, including diabetes, hypertension, and cancer, through educational programming for physicians and other stakeholders;
- Reverse the troubling increases in race/ethnic-based health inequities such as maternal mortality; and
- Promote and expand funding for programs that attract a more diversified physician workforce, increasing the number of minority faculty including Black, Latinx, Native American, female and LGBTQ faculty teaching in medical schools and expanding medical school pipeline programs in rural and urban areas to address the shortage of physicians in medically underserved areas of New York State.

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