

PERSPECTIVES

Race, Racism, and the Policy of 21st Century Medicine

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This perspective describes three new policies passed at the November 2020 Special Meeting of the American Medical Association House of Delegates. These policies (1) denounce racism as a public health threat; (2) call for the elimination of race as a proxy for ancestry, genetics, and biology in medical education, research, and clinical practice; and (3) decry racial essentialism in medicine. We also explore the social and institutional context leading to the passage of these policies, which speak directly to the harmful legacy of racism in America, and its insidious impact on the healthcare system.

INTRODUCTION

It is no new thing that considerable and fundamental differences in health status exist in the United States and abroad across racialized communities, across communities separated by socioeconomic status, and as a consequence of other socially constructed, intersectional identities, which bear on communities' abilities to make healthy choices [1,2]. These harmful inequities are well established, yet avoidable, and become particularly dangerous against the backdrop of catastrophic public health and social disruptions, namely structural racism.

As an example, the global pathogenic phenomenon of SARS CoV-2 (to which we will refer as COVID-19) underscores the failures of our nation's healthcare system to address immediate and enduring health threats [3]. It highlights longstanding social-political constructs

that define how our institutions value marginalized and minoritized patients, and the communities where they live, play, work, and die. The epidemic emphasizes the urgency for strategic, equitable investments in our public health infrastructure. It calls for a bold reimagining of the policies and practices, which determine the medical tradition, and the direction in which our healthcare system is shifting. In the wake of this shift, providers are presented with newer, more complex questions, which stretch beyond the traditional realms of American medicine. How do we reimagine our US health system, redistribute resources and opportunities, and reflect on the social and economic tolls of worldwide crises? Beyond the traditional healthcare continuum, what will it take to prevent avoidable deaths and injuries, and what will it take to strategically strive toward a more equitable existence? While there are many factors at play, address-

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Abbreviations: AMA, American Medical Association; HOD, House of Delegates.

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ing these questions necessitates evaluating policies that govern the American healthcare system and its actors. It takes re-envisioning political determinants of health and health spheres [4]. It will take intentional creation of policies and practices within advocacy arenas that move the needle toward equity, antiracism, and health in all policies [5-6]. Foremost, such work takes an unquestionable recognition of racism—and its caustic associates of other “isms”—as a public health threat [7-9].

During its November 2020 Special Meeting, the American Medical Association (AMA) House of Delegates (HOD), for the first time in its 174-year existence, passed an historic suite of policies decrying the harms of racism in healthcare and across social realms that impact health. There was no straightforward path to reach this point, nor even will the records show uncontested consensus amongst the more than 600 HOD voting Delegates on the way to passage of these policies. Indeed, prioritizing equity is an outcome of political will as well as democracy. Through this policies-building process, collaboration and strategic coordination prevailed between the AMA HOD Medical Students Section (MSS), the Minority Affairs Section (MAS), the Women Physicians Section, and countless allies within the AMA Board of Trustees, Councils, senior management, and across the AMA staff, particularly from the AMA Center for Health Equity. The voices of current and future physicians with intersectional identities are stronger than ever. Many whom are HOD Delegates were moved by the 2020 murders of Ahmaud Arbery, Breonna Taylor, and George Floyd—such conviction was particularly reflected in their staunch testimonials in support of the November 2020 policies. Through these policies, the American Medical Association cements its core commitment to advancing health equity, particularly in medical education, healthcare delivery, research, and practice.

This paper endeavors to capture—albeit briefly—the continuum of policy and organizational detractions, and also the steps AMA has firmly taken toward achieving equity in healthcare. It begins by briefly outlining the infrastructure of the AMA HOD, which is a pertinent perspective to understanding how policies are presented, considered, and accepted (or not) via the HOD democratic process. It then segues into descriptions of the intent of three HOD November 2020 antiracism policies, specifically. While there were other significant policies also passed alongside the three highlighted policies, this paper will only comment on how they bolster the power of the antiracism HOD policies, leaving opportunity for future, more in-depth conversation. The authors then describe the arc of AMA leadership and several critical events over time—some of which have been deeply harmful to marginalized and minoritized communities, and unhelpful toward advancing equity for all—that led to the approval

of the HOD triad antiracism policies. The perspective concludes on a hopeful note that such work is only the beginning of the AMA’s commitment to achieving health equity in the 21st century.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

A Brief History on AMA HOD Infrastructure

As the largest association representing American physicians and medical students, the AMA is governed by its House of Delegates [10], with over 600 voting members. The AMA mission is to “promote the art and science of medicine and the betterment of public health [11],” and it largely relies on the activities of the HOD to see through its mission. Established in 1901, the HOD is “the legislative and policy-making body of the American Medical Association. State medical associations and national medical specialty societies are represented in the HOD along with AMA sections, national societies such as AMWA, AOA and the NMA, professional interest medical associations, and the federal services, including the Public Health Service [12].”

The next section specifically highlights the three antiracism policies adopted in November 2020 during the AMA HOD Special Meeting. They principally and explicitly speak to the harmful legacy of racism in America, and its insidious impact on the healthcare system.

AMERICAN MEDICAL ASSOCIATION HISTORIC POLICIES ON RACE

Racism as a Public Health Threat, AMA Health Policy H-65.952

AMA’s recent adoption of the policy declaring *Racism as a Public Health Threat* acknowledges that structural, systemic, and interpersonal forms of racism and bias exist across all the social determinants of health, and across medical research. Each form of racism is a threat to society, is a barrier to quality healthcare delivery, and needs to be unrooted. This policy also institutes a charge to “healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations [13].” It furthermore calls upon government and non-government agencies to evaluate their budgets, and intentionally create research lines dedicated to uncovering the epidemiological risks associated with bearing racism across one’s life course. Lastly, this policy implores technological innovators to tease out the implications of racial bias within medical algorithms and like innovations.

Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice, AMA Health Policy H-65.953

Race is a social construct [14], and the physician and medical student body of the AMA agrees that it is “distinct from ethnicity, genetic ancestry, or biology [15].” The infamous use of race as a proxy variable across centuries of medical, epidemiological, and genetics research has contributed to histories of painful interventions, of delayed medical treatment, and of erroneous medical decision-making. The research implications of the variable have oftentimes locked marginalized and minoritized peoples out of life-enhancing or life-saving healthcare delivery [16]. The designers of this policy were inspired by research underscoring this point. Race is threaded within the fibers of our oldest social institutions and the policies that govern them [17]. Rather than focusing myopically on race, this policy calls for the continuum of medical professionals, and those in training, to instead focus on the long-time impact of structural racism on medicine. It also calls for medical institutions to focus on restructuring medical school curricula, or like transformative efforts.

Racial Essentialism in Medicine, AMA Directive D-350.981

As health policies, the first two describe the philosophies that are to be normalized across the AMA membership, and across the medical field. As a directive, *Racial Essentialism in Medicine* is a continuation of H-65.953 in that it definitively outlines the actions the AMA will take to quell the false conflation of race with racism in medicine and in medical research. It explicitly names stakeholders with whom the AMA will collaborate, “including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism [18],” as well as collaborators to do away with medical algorithmic bias.

As standalone policies passed by a non-partisan body, which governs conduct of physicians nation-wide, the three aforementioned are singularly significant policy strides. As a timely triad, these policies provide a firm foundation through which the AMA may forever change the course of medical practice. Moreover, this consequential effort is just as much a culmination of work generated by longstanding champions within the AMA. Not to be lost upon readers is the passage of these proclamations during what is already ranked among the topmost devastating of pandemics our world has witnessed [19]. Together, these policies are a timely response to the unique confluence of great social disruptions via the scourge of the COVID-19 pandemic, the violence perpetuated

by police brutality and racially motivated hatred, and a pivotal US Presidential race. These intersectional events make the adoption of these three AMA HOD policies to arguably be of legacy proportion.

HIGHLIGHT OF PIVOTAL AMA LEADERSHIP TOWARD EQUITY OVER TIME

To be certain, the commitment to advancing equitable and antiracist medical policies did not begin with the AMA’s November 2020 Special Meeting. While the AMA has intermittently condemned racial discrimination and its harms across the late 19th and throughout the 20th centuries, it began its earnest, consistent, internal journey toward racial reconciliation in the 21st century. This section will focus exclusively on some of those efforts, providing some historical perspective as to how the AMA could today reach a point of passing antiracist policies.

In 2004, the AMA established the Commission to End Health Care Disparities (the Commission). The Commission was an appointed joint body of physicians between the AMA, the National Medical Association (NMA), and the National Hispanic Medical Association (NHMA). Its collective purpose was to (1) influence government actions so as to curtail disparities in healthcare; (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 [20]. In 2008, the AMA issued a public apology to the NMA—the largest organized body of Black physicians established in 1895 in response to barred AMA membership through the 1960’s—for its explicit role in stymieing the professional development of the Black physician workforce, and therefore the consequent dearth of medical professionals available to treat Black and Brown residents of the United States [21-23]. Current-day research cites the lack of a representative health workforce as a persisting barrier to availing quality care to marginalized and minoritized communities, and to the downstream causes of health inequities along racial lines [24].

By 2017, the AMA HOD called for an internal report on the state of health equity. In the following year, the contents of Report 33, A-18, the “Plan for Continued Progress Toward Health Equity,” led to a pivotal directive, D-180.981. This directive called for the development of “an organizational unit, eg., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities [25].” Thereafter, in 2019, the AMA Center for Health Equity was established upon the historic appointment of the AMA’s first Chief Health Equity Officer,

Dr. Aletha Maybank [26].

Over the past quarter century, the AMA HOD has passed critical policies toward the advancement of optimal health for all by concentrating on the role of medicine at the nexus of race/ethnicity, gender, sexual identity, immigration status, country of origin, and disability status. During its November 2020 Special Meeting, the AMA HOD passed several such policies intentionally designed to address health disparities and inequities concerning the aforementioned protected status classes, as well as policies on police reform, immigration reform, and bias within clinical algorithms. Each of those policies deserve commendation.

WHERE DOES THE AMA, MEDICINE, & THE NATION GO FROM HERE?

As illustrated, the American Medical Association has not always been explicitly committed to an equity agenda, yet tides are changing. As a bastion of healthcare advocacy and policy, the AMA is continuously heralded within political spaces: its leaders are consistently called upon by Congress to deliver testimony at hearings, to respond to health policies of great import, and its lobbying force is bar none. This power is profound, and now profoundly rooted in accountability to advance equitable, anti-racist commitments. Given that race, albeit a social construct, is imbued across every American institution, it follows that antiracist and equitable policies are necessary to reimagine and restructure the role of race on health outcomes, and, more broadly, on life opportunity [8]. The mark of these three outlined policies is indelible. In time, it will become exceedingly clear the path they have produced with respect to the policies that AMA will continue to pass within the HOD, as well as the policies it will critically evaluate and support, whether Congressionally via the AMA Advocacy Business Unit, or locally via the state medical societies.

The AMA recognizes the power of its institutional policies to diffuse across social membranes, influencing other organizational outlooks on intentional commitments to antiracism. Myriad medical and public health leaders and organizations have also taken up the mantle of advancing equity and antiracism through their organizational and governing bodies. Beyond the AMA, long-standing American institutions are grappling—some better and more favorably than others—to acknowledge the myriad social and behavioral factors that underlie associations with race, racism, and health status outcomes. While there is more emphasis now on social and behavioral factors, which are often addressed through antibias and cultural competence trainings, there is continuous urgency to push attention and resources toward systemic, structural, organizational, institutional, and political

conditions. Many health systems across the country are now developing new models to name and confront these root causes of poor health, moving healthcare (including preventive medicine) further “upstream.”

As of January 20, 2021, the nation came under a new presidential administration, one which is under intense pressure and scrutiny to address the COVID-19 pandemic, as well as the enduring public health crisis of racism, through actionable directives stemming from equitable and antiracist policies. In unprecedented fashion, and on his first day in office, President Biden signed four executive orders to advance racial equity, veritably beginning a new era of American leadership [27]. As the advocating voice of the physician, the AMA’s attention to administrative actions is unwavering and the Presidential commitment to equity speaks volumes to the AMA. The three AMA HOD antiracist policies harken not only to an awakening at the change of medical leadership—it is also in lockstep with national leadership, and positions the AMA to openly support Congressional, Federal, and state level antiracist policies: the AMA cannot otherwise support policies at these levels if it does not already have similar, existing HOD policy.

The insidious impact of racism on health and on the nation’s systems are not just historical, but they are also contemporary problems. Moreover, it is not just the AMA that has had to contend with this problem. Medicine, scholarship, and our leaders overall have an obligation to rise to the moment and beyond, specifically calling for the acknowledgement of the social construction of race, and the harmful impact of racism on the body’s biology, and on the nation’s socio-political structures [28]. As the nation’s critical consciousness around a racialized society matures and its willingness to assign equity accountability measures at the institutional level takes hold, one may be hopeful this moment is more so a movement. A movement that recognizes the inextricable link between 21st century healthcare and justice.

Disclaimer: The thoughts in this article are those of the authors and do not necessarily represent AMA policy.

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