Whereas, The Civil Rights Act prohibits discrimination based on race, color, religion, sex, or national origin; and

Whereas, The racial wage gap persists across the labor market in the United States, meaning that people of color earn less than their white counterparts in the same professions, conducting the same work, with the same education and experience; and

Whereas, The Bureau of Labor Statistics reports that in 1979 black men earned 80% of what white men earned, whereas in 2016 black men earned 70% of what white men earn, suggesting a worsening of the racial pay gap; and

Whereas, The American College of Physicians has shown that after controlling for age, sex, race, hours worked, and state of residence, Black physicians made $194,444 annually, compared to $228,585 for White physicians – a difference of $34,141; and

Whereas, Black male physicians earn substantially less than white male physicians after adjustment for physician specialty practice characteristics, age, and hours worked; and black female physicians earn even less than their black male counterpart with adjustments accounting for characteristics of physician and practice; and

Whereas, White female physicians made 19 percent and Black female physicians made 29 percent less than their white male counterparts after controlling for hours worked, years of practice, practice ownership status, board certification status, IMG status, type of degree, demographics of practice, and proportion of Medicare and Medicaid patients; and

Whereas, Black male physicians are more likely to work in primary care and to treat Medicaid patients compared with white male physicians, adjustment for these and other practice characteristics, does not eliminate, or even significantly reduce, the estimated differences in earnings; and

Whereas, A study of 128 academic medical centers found that Black or Hispanic faculty constituted only 5% of new academic hires and had significantly longer promotion timelines when compared to their white counterparts, after factors such as gender, tenure status, degree, and NIH award status were adjusted for. Underrepresented minority (URM) faculty were still less likely to be promoted at all levels; therefore be it
RESOLVED, That our American Medical Association support measures of racial pay awareness and the specific challenges that minority physicians face in regards to equal pay financial attainment (New HOD Policy); and be it further

RESOLVED, That our AMA support efforts to increase the transparency and accountability of physician earnings through establishing transparency measures, in which physicians can access information including but not limited to the salaries and race of medical physicians. (New HOD Policy)

Fiscal Note:

Received: 08/28/19

References:

RELEVANT AMA POLICY

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979

1. Our AMA supports increasing the representation of minorities in the physician population by:
   (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels. (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties. (3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions. (4) Increasing the supply of minority health professionals. (5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty. (6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores. (7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students. (8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18
Revisions to AMA Policy on the Physician Workforce H-200.955

It is AMA policy that:

1. any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.

2. Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research.

3. The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.

4. In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.

5. There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups.

6. There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.

7. Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.

8. Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agencies physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.

9. Our AMA will consider physician retraining during all its deliberations on physician workforce planning.

Citation: CME Rep. 2, I-03; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CME Rep. 15, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 324, A-17; Appended: CME Rep. 01, A-19