

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007  
(I-19)

Introduced by: Medical Student Section

Subject: Addressing the Racial Pay Gap in Medicine

Referred to: Reference Committee on Amendments to Constitution and Bylaws  
(\_\_\_\_\_, Chair)

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1 Whereas, The Civil Rights Act prohibits discrimination based on race, color, religion, sex, or  
2 national origin<sup>1</sup>; and

4 Whereas, The racial wage gap persists across the labor market in the United States, meaning  
5 that people of color earn less than their white counterparts in the same professions, conducting  
6 the same work, with the same education and experience<sup>2</sup>; and

8 Whereas, The Bureau of Labor Statistics reports that in 1979 black men earned 80% of what  
9 white men earned, whereas in 2016 black men earned 70% of what white men earn, suggesting  
10 a worsening of the racial pay gap<sup>3</sup>; and

12 Whereas, The American College of Physicians has shown that after controlling for age, sex,  
13 race, hours worked, and state of residence, Black physicians made \$194,444 annually,  
14 compared to \$228,585 for White physicians – a difference of \$34,141<sup>4</sup>; and

16 Whereas, Black male physicians earn substantially less than white male physicians after  
17 adjustment for physician specialty practice characteristics, age, and hours worked; and black  
18 female physicians earn even less than their black male counterpart with adjustments accounting  
19 for characteristics of physician and practice<sup>5</sup>; and

21 Whereas, White female physicians made 19 percent and Black female physicians made 29  
22 percent less than their white male counterparts after controlling for hours worked, years of  
23 practice, practice ownership status, board certification status, IMG status, type of degree,  
24 demographics of practice, and proportion of Medicare and Medicaid patients<sup>5</sup>; and

26 Whereas, Black male physicians are more likely to work in primary care and to treat Medicaid  
27 patients compared with white male physicians, adjustment for these and other practice  
28 characteristics, does not eliminate, or even significantly reduce, the estimated differences in  
29 earnings<sup>5</sup>; and

31 Whereas, A study of 128 academic medical centers found that Black or Hispanic faculty  
32 constituted only 5% of new academic hires and had significantly longer promotion timelines  
33 when compared to their white counterparts, after factors such as gender, tenure status, degree,  
34 and NIH award status were adjusted for. Underrepresented minority (URM) faculty were still  
35 less likely to be promoted at all levels<sup>6</sup>; therefore be it

1 RESOLVED, That our American Medical Association support measures of racial pay awareness  
2 and the specific challenges that minority physicians face in regards to equal pay financial  
3 attainment (New HOD Policy); and be it further

4  
5 RESOLVED, That our AMA support efforts to increase the transparency and accountability of  
6 physician earnings through establishing transparency measures, in which physicians can  
7 access information including but not limited to the salaries and race of medical physicians. (New  
8 HOD Policy)

Fiscal Note:

Received: 08/28/19

**References:**

1. Civil Rights Act of 1964, Pub.L. 88-352, 78 Stat. 241 (1964)
2. Treadwell HM. Wages and Women in Health Care: The Race and Gender Gap. *Am J Public Health*. 2019;109(2):208–209. doi:10.2105/AJPH.2018.304866
3. Bureau of Labor Statistics <https://www.bls.gov/opub/mlr/2017/beyond-bls/the-unexplainable-growing-black-white-wage-gap.htm>
4. Grisham, Sarah. "MedscapePhysicianCompensationReport2017." [Medscape](http://www.medscape.com/slideshow/compensation-2017-overview-6008547#1). April 5, 2017. Accessed August 23, 2017. <http://www.medscape.com/slideshow/compensation-2017-overview-6008547#1>
5. Ly DP, Seabury SA, Jena AB. Differences in incomes of physicians in the United States by race and sex: observational study. *BMJ*. 2016;353:i2923. [Differences in incomes of physicians in the United States by race and sex: observational study <https://www.bmjjournals.org/content/353/bmji2923>]
6. Nunez-smith M, Ciarleglio MM, Sandoval-schaefer T, et al. Institutional variation in the promotion of racial/ethnic minority faculty at US medical schools. *Am J Public Health*. 2012;102(5):852-8.

**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 agencys 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