

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(A-22)

Introduced by: Medical Student Section

Subject: Evaluating Scientific Journal Articles for Racial and Ethnic Bias

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Race is a self-identified social construct that results in differential treatment of groups
2 that leads to social inequity on people's health^{1,2}; and
3

4 Whereas, According to the U.S. Census 2020 Bureau, ethnicity refers to an individual's self-
5 identification of their origin or descent, "roots," heritage, or place where the individual or their
6 parents or ancestors were born³; and
7

8 Whereas, Our AMA recognizes that race and ethnicity are conceptually distinct (H-460.924);
9 and
10

11 Whereas, In practice, race and ethnicity are often inappropriately used interchangeably as
12 demonstrated across the United States where the terms "Latino/a/x, Hispanic, Spanish and
13 Chicano/a/x" have been used interchangeably with race in case report⁴⁻⁷; and
14

15 Whereas, Racial and ethnic categories are dependent on self-identification and self-reporting of
16 origin and cultural heritage, constructs which can change over time^{8,9}; and
17

18 Whereas, Racial and ethnic classification is highly inconsistent in literature, and evidence-based
19 consensus is necessary for optimal use of self-identified race as well as geographical
20 ancestry¹⁰; and
21

22 Whereas, In 2017, our AMA recognized assumptions attributed to race and ethnicity can
23 contribute to the inequitable treatment of patients as it relates to evidence-based medicine¹¹;
24 and
25

26 Whereas, A current review examining ten studies and over 1.5 million participants demonstrated
27 an association between ethnic minorities including Black, Hispanic, South Asian, Southeast
28 Asian, and Chinese, and greater wait time for medical care for chest pain in the emergency
29 department¹²; and
30

31 Whereas, In a study of 4.2 million Medicare beneficiaries who utilized home health services in
32 2015, there was substantial variation between states in administrative data misclassification of
33 self-identified Hispanic, Asian American/Pacific Islander, and American Indian/Alaska Native
34 beneficiaries¹³; and
35

36 Whereas, In a systematic analysis of race/ethnicity and GERD, it was found that only 25 of the
37 62 studies provided complete descriptions of their study populations¹⁴; and
38

39 Whereas, Conclusions drawn from past interpretations of race and ethnicity have been found to
40 be inconsistent with current understanding of race and ethnicity¹⁵; and

Whereas, The use of race as a correction factor in the calculation of estimated glomerular filtration (eGFR) has been shown to be unnecessary and less precise than biological measures and has led to irreproducible results¹⁶; and

Whereas, The race correction factor in eGFR may lead to a delayed referral to a specialist or transplantation and worse outcomes in Black patients¹⁶; and

Whereas, Race correction factors are still commonplace in cardiology, nephrology, urology, and obstetrics even though many were developed under the belief that race is a useful proxy for biology¹⁶⁻¹⁸; and

Whereas, Past literature has incorrectly favored a genetic explanation for the difference in birth outcomes between African American and White women⁴; and

Whereas, Current literature states that environmental factors play a greater role in explaining the greater risk of infant mortality in Black women¹⁹; and

Whereas, The rates of low birth weight and very low birth weight babies among sub-Saharan African-born Black women is less than that of U.S.-born Black women and approximates those of U.S.-born White women, suggesting no significant genetic basis to race differences⁴; and

Whereas, Our AMA Board of Trustees on June 7th, 2020 recognized racism as an urgent threat to public health and resolved to work towards dismantling racist and discriminatory practices across all of healthcare care, and our House of Delegates has adopted multiple policies recognizing racism as a public health threat (H-65.952) and the harm of racial essentialism in medicine and of using race as biology (D-350.981, H-65.953)²⁰; and

Whereas, Our AMA states that “race and ethnicity are valuable research variables when used and interpreted appropriately” and “continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients” (H-460.924); and

Whereas, The tools for the evaluation of research integrity exist to determine the strength of their validity and limits of their bias, however lack similar tools to evaluate racial and ethnic bias²¹; therefore be it

RESOLVED, That our American Medical Association support major journal publishers issuing guidelines for interpreting previous research which define race and ethnicity by outdated means (New HOD Policy); and be it further

RESOLVED, That our AMA support major journal publishers implementing a screening method for future research submission concerning the incorrect use of race and ethnicity. (New HOD Policy)

Fiscal Note: Not yet determined

Received: 04/08/22

References

1. Roberts D. *Fatal Invention: How Science, Politics, and Big Business Re-Create Race in the Twenty-First Century*. New York, NY: The New Press; 2011.
2. Witzig R. The medicalization of race: scientific legitimization of a flawed social construct. *Ann Intern Med*. 1996;125(8):675-679. doi:10.7326/0003-4819-125-8-199610150-00008
3. Ethnic Origin or Race. Census. <https://www.census.gov/glossary/>. Accessed August 27, 2020.

4. Matoba N, Collins JW. Racial disparity in infant mortality. *Seminars in Perinatology*. 2017;41(6):354-359. doi:10.1053/j.semperi.2017.07.003
5. Pareek M, Bangash MN, Pareek N, et al. Ethnicity and COVID-19: an urgent public health research priority. *Lancet*. 2020;395(10234):1421-1422. doi:10.1016/S0140-6736(20)30922-3
6. Pan D, Sze Shirley, Minhas JS, et al. The impact of ethnicity on clinical outcomes in COVID-19: A systematic review. *Lancet*. 2020;(100404). doi: [10.1016/j.eclinm.2020.100404](https://doi.org/10.1016/j.eclinm.2020.100404)
7. Kim L, Whitaker M, O'Halloran A, et al. Hospitalization Rates and Characteristics of Children Aged <18 Years Hospitalized with Laboratory-Confirmed COVID-19 — COVID-NET, 14 States, March 1–July 25, 2020. *MMWR Morb Mortal Wkly Rep*. ePub: 7 August 2020. DOI: <http://dx.doi.org/10.15585/mmwr.mm6932e3external icon>.
8. Anderson MR, Moscou S, Fulchon C, Neuspiel DR. The Role of Race in the Clinical Presentation. *Fam Med* 2001;33(6):430-434
9. Liebler C, Rastogi S, Fernandez L, Noon J, Ennis SR. Americas Churning Races: Race and Ethnic Response Changes between Census 2000 and the 2010 Census. 2017. doi:10.31235/osf.io/d837h
10. Zhang F, Finkelstein J. Inconsistency in race and ethnic classification in pharmacogenetics studies and its potential clinical implications. *Pharmgenomics Pers Med*. 2019;12:107-123. Published 2019 Jul 2. doi:10.2147/PGPM.S207449
11. Miller, R. Black, gay, female: Multiple identities affect health outcomes. American Medical Association. Accessed September 20, 2020. <https://www.ama-assn.org/delivering-care/population-care/black-gay-female-multiple-ide>
12. Wechkunanukul K, Grantham H, Damarell R, Clark RA. The association between ethnicity and delay in seeking medical care for chest pain. *JBI Database of Systematic Reviews and Implementation Reports*. 2016;14(7):208-235. doi:10.11124/jbisnr-2016-003012
13. Grafova IB, Jarrín OF. Beyond Black and White: Mapping Misclassification of Medicare Beneficiaries Race and Ethnicity [published online ahead of print, 2020 Jul 7]. *Med Care Res Rev*. 2020;1077558720935733. doi:10.1177/1077558720935733
14. Craven MR, Kia L, O'Dwyer LC, Stern E, Taft TH, Keefer L. Systematic review: methodological flaws in racial/ethnic reporting for gastroesophageal reflux disease. *Dis Esophagus*. 2018;31(3):dox154. doi:10.1093/dote/dox154
15. Vyas DA, Eisenstein LG, Jones DS. Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms. *New England Journal of Medicine*. 2020;383(9):874-882. doi:10.1056/nejmms2004740
16. Vyas DA, Eisenstein LG, Jones DS. Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms. *New England Journal of Medicine*. 2020;383(9):874-882. doi:10.1056/nejmms2004740
17. Bonham VL, Green ED, Pérez-Stable EJ. Examining How Race, Ethnicity, and Ancestry Data Are Used in Biomedical Research. *Jama*. 2018;320(15):1533. doi:10.1001/jama.2018.13609
18. Hernandez N, Song Y, Noble V, Eisner B. Pd47-10 Predicting Ureteral Stones In Emergency Department Patients With Flank Pain: An External Validation Of The Stone Score. *Journal of Urology*. 2016;195(4S). doi:10.1016/j.juro.2016.02.2698
19. El-Sayed AM, Paczkowski M, Rutherford CG, Keyes KM, Galea S. Social Environments, Genetics, and Black-White Disparities in Infant Mortality. *Paediatr Perinat Epidemiol*. 2015;29(6):546-551. doi:10.1111/ppe.12227
20. AMA Board of Trustees pledges action against racism, police brutality. <https://www.ama-assn.org/press-center/ama-statements/ama-board-trustees-pledges-action-against-racism-police-brutality>. Published June 7, 2020. Accessed August 27, 2020.
21. Page MJ, McKenzie JE, Higgins JPT. Tools for assessing risk of reporting biases in studies and syntheses of studies: a systematic review. *BMJ Open*. 2018;8(3):e019703. Published 2018 Mar 14. doi:10.1136/bmjopen-2017-019703

RELEVANT AMA POLICY

Code of Medical Ethics 7.1.5

Biomedical and health research is intended to advance medical knowledge to benefit future patients. To achieve those goals physicians who are involved in such research maintain the highest standards of professionalism and scientific integrity.

Physicians with oversight responsibilities in biomedical or health research have a responsibility to ensure that allegations of scientific misconduct are addressed promptly and fairly. They should ensure that procedures to resolve such allegations:

- (a) Do not damage science.
- (b) Resolve charges expeditiously.
- (c) Treat all parties fairly and justly. Review procedures should be sensitive to parties' reputations and vulnerabilities.
- (d) Maintain the integrity of the process. Real or perceived conflicts of interest must be avoided.
- (e) Maintain accurate and thorough documentation throughout the process.
- (f) Maintain the highest degree of confidentiality.
- (g) Take appropriate action to discharge responsibilities to all individuals involved, as well as to the public, research sponsors, the scientific literature, and the scientific community.

Issued: 2016

Code of Medical Ethics Opinion 8.5

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate

variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics. To fulfill this professional obligation in their individual practices physicians should:

- (a) Provide care that meets patient needs and respects patient preferences.
- (b) Avoid stereotyping patients.
- (c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
- (d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
- (e) Encourage shared decision making.
- (f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

- (g) Help increase awareness of health care disparities.
- (h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
- (i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

Issued: 2016

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority:

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields

related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984

Our AMA will pursue avenues to collaborate with the American Public Health Association's National Campaign Against Racism in those areas where AMA's current activities align with the campaign.

Citation: BOT Action in response to referred for decision Res. 602, I-15

Improving the Health of Black and Minority Populations H-350.972

Our AMA supports:

- (1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
- (2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
- (3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
- (4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

Citation: CLRPD Rep. 3, I-98; Reaffirmation A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 1, A-21

Reducing Racial and Ethnic Disparities in Health Care D-350.995

Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:

- (1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
- (2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
- (3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

Citation: BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

Strategies for Eliminating Minority Health Care Disparities D-350.996

Our American Medical Association will continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate.

Citation: (Res. 731, I-02; Modified: CCB/CLRPD Rep. 4, A-12)

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.

2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for 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.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20

Racial Essentialism in Medicine D-350.981

1. Our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities.
2. Our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, 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.
4. Our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors.
5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.

Citation: Res. 10, I-20

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

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category "race" can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.

Citation: Res. 11, I-20;