REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-I-22

Subject:	Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment
Presented by:	Sandra Adamson Fryhofer, MD, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

BACKGROUND

At the November 2021 Special Meeting of the House of Delegates (HOD), the HOD adopted Policy H-65.950, which reads as follows:

> Our AMA recommends preferred terminology for protected personal characteristics to be used in AMA policies and position statements.

This report: 1) summarizes key points and findings of Board of Trustees Report 5-N-21, updates from other policies adopted by our AMA in 2021, relevant information from the AMA's Strategic Plan to Embed Racial Justice and Advance Health Equity ("Strategic Plan") and the AMA-AAMC Advancing Health Equity: A Guide to Language, Narrative and Concepts, and feedback from stakeholders ("Narrative Guide"); and 2) recommends preferred terminology for protected personal characteristics to be used in AMA policies and position statements.

DISCUSSION

Language matters especially in medicine. How physicians transcribe and communicate about healthcare with other healthcare workers and with patients adds context and framing to any discussion. The significance of language is even more critical when it concerns sensitive topics, including those involving race, ethnicity, gender, sexual orientation, and gender identity and how their use, misuse, or non-use impact care. Engaging in such discussions within medicine provides a chance to not only showcase language's fluidity in action, essentially the manner in which terms and/or phrases evolve as individuals and groups decide on new ways to identify themselves, but to also advance health equity. Equity work within healthcare requires acknowledging and reconsidering one's beliefs about health, healthcare, health systems and society. Related to this is the consideration of the language and narratives that consistently contribute to our thoughts and actions.

Language and identity often go together and are critical within health equity. Both are fluid and most importantly, social constructs, meaning they are derived from humans and can change as time progresses. For example, the acronym BIPOC is used to collectively refer to those who identify as Black, Indigenous, and People of Color; it was created within the last decade. Some view it as a shift away from using other terms such as "marginalized" and "minority" and is another term used to unify and amplify communities that have long been shunned and/or ignored. However, there are others that have differing opinions. Jonathan Rosa, sociocultural and linguistic anthropologist, and associate professor at Stanford University explains that BIPOC "presupposes a kind of solidarity

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and a shared positionality that doesn't play out in practice for a lot of people, and in fact obscures more than it reveals from some perspectives." It can also have an impact on research. Some scholars have argued that aggregating data can mask critical in-group differences and disparities, limiting efforts to specifically target resources. AMA has acknowledged this in recent years through the adoption of Policy D-350.979 at the 2021 Interim Meeting directing the organization to add "Middle Eastern/North African (MENA)" as a separate racial category on all AMA demographics forms; (2) advocate for the use of "Middle Eastern/North African (MENA)" as a separate race category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education. Therefore, the acronym can be used in certain circumstances, but should not be used in quantitative reporting to unnecessarily aggregate groups; instead, disaggregated data should be used to depict the experiences of groups (see AMA AAPI Data Report).

Additional key terms to consider such as sex and gender are often mistakenly used interchangeably. Within medicine, sex or "sex assigned at birth" is a label typically given by a physician based on the genitals a person is born with, but over time that very label may not align with how they identify. According to *The Oxford Handbook of Gender and Politics*, gender, refers to the social, psychological, and emotional traits, attitudes, norms and behaviors, often influenced by society's expectations, that classify someone as man, woman, both, or neither. The American Academy of Pediatrics defines gender identity as "one's internal sense of who one is, which results from a multifaceted interaction of biological traits, developmental influences, and environmental conditions. It may be male, female, somewhere in between, a combination of both, or neither (i.e., not conforming to a binary conceptualization of gender)."

Language usage is critical. At a time when so many are working to not only diversify medicine, but promote antiracism, the terms and phrases that are amplified can have lasting impacts that can cause harm for both physicians and patients.

Board Report 5-N-21 notes: "Federal, state, and local law establish a baseline, identifying the minimum constellation of characteristics with respect to which discrimination should not be tolerated, based on the history of discrimination in the U.S." The landscape related to protected personal characteristics is constantly evolving (e.g., update to Title IX), so any recommendation on terminology will need to be flexible in its wording and regularly updated to remain in compliance.

Board of Trustees Report 5-N-21 also found protected personal characteristics mentioned in existing policy of the AMA and other organizations at frequencies detailed in Appendix A, with minor adjustments made accounting for additional policy adopted by the AMA since the report was adopted (e.g., Policy H-350.960, Underrepresented Student Access to US Medical Schools).

Finally, while not policy, the Strategic Plan and the Narrative Guide offer language (see Appendices B and C). The Strategic Plan at various points (see pages 11-16) mentions: "race, ethnicity, gender, sexual orientation, ability and country of origin (i.e., International Medical Graduates)," "gender, gender identity, sexual orientation, disability, age, class/socioeconomic status, citizenship status and language," "marginalized (women, LGBTQ+, people with disabilities, International Medical Graduates) and minoritized (Black, Indigenous, Latinx, Asian) physicians," "race/ethnicity, gender, sexual identity, immigration status, country of origin, language and disability status," and "race/ethnicity, gender, socioeconomic status, ability status, LGBTQ+ identity, literacy." The Narrative Guide at various points (see pages 9-15) mentions: "formerly incarcerated/returning citizen/persons with a history of incarceration," "sex assigned at birth," and "ethnicity, nationality, class, or other status/identities." The Narrative Guide stresses the importance of avoiding "dehumanizing language" and instead "offering equity-based, equity

explicit, and person-first alternatives" and advises us to "describe people as having a condition or circumstance, not being a condition" and "humanize those you are referring to by using people or persons." Person-first or people-first formulations include: "people with…," "people experiencing…," and "people identifying as…." However, the Narrative Guide notes that "different communities and individuals have different standards and preferences" regarding person-first language.

RECOMMENDATION

Based on a review of internal policies, the Strategic Plan and Narrative Guide, the Board of Trustees recommends that the following be adopted, and the remainder of this report be filed:

1. That our AMA amend Policy H.-65.950 by addition to read as follows:

   Our AMA recognizes broad and evolving protected personal characteristics spanning identity, origin, and status that include those outlined by regulatory authorities overlapping with those prioritized by AMA. To prevent misunderstandings and facilitate collaboration to move medicine forward, AMA ~~recommends~~ acknowledges preferred terminology for protected personal characteristics outlined in the actual sources used in the 2021 AMA Strategic Plan to Embed Racial Justice and Advance Health Equity and the AMA-AAMC Advancing Health Equity such as the CDC's Health Equity Guiding Principles for Inclusive Communication ~~to~~ that may be used in AMA policies and position statements. (Modify Current HOD Policy)

   Fiscal Note: Less than $500

APPENDIX A: Terminology Used in Existing Policy from AMA and Other Organizations

Characteristic	**Federal Agencies (DOE, EEOC, HHS)**	**AMA Policy**	**Other Professional Societies (Convenience Sample)**	**Schools (Convenience Sample)**
Affiliational preferences				1
Age	3	10	8	10
Ancestry			2	4
Appearance			1	1
Body habitus			1	
Citizenship		1	1	1
Color	3	4	7	10
Country of education or origin		1		
Creed		3	1	4
Culture		1		
Degree of medical dependency		1		
Dependent status				
Disability	3	8	10	10
Disability, present or predicted		1		
Drug abuse		1		
Economic		1		
Education			1	
Employment status				
Ethnic origin		5	8	3
Ethnicity		1		
Expected length of life		1		
Family status / responsibilities				1
Future plans for marriage or children		1		
Gender		7	7	2
Gender expression		2	3	3
Gender identity	1	10	7	10
Genetic information	1	3	1	8
Health / health status		1	1	
Immigration status			2	
International medical graduate		2		
Language preference			2	
Living donor status		1		
Marital status		4	2	4
Matriculation				1

Medical condition			1	2
Military/veteran status			5	10
National origin	3	7	8	10
Order of protection status				1
Other		4		1
Other legally protected basis				1
Other basis prohibited by law			2	
Other human condition or choice			1	
Other personal category			1	
Other protected group / category / characteristic			2	3
Other social category			1	
Participation in a PHP		1		
Political opinion / affiliation			1	1
Pregnancy	1		1	5
Professional experience			1	
Professional experience / profession		1		
Quality of life		1		
Race	3	11	12	10
Religion	1	8	11	10
Rurality		1		
Sex	3	9	5	10
Sexual orientation	1	10	11	10
Social status or condition			1	
Socioeconomic status			4	
Socioeconomic origin		1		
Unemployed status				1
Zip code			2	

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APPENDIX B: Definitions and Levels of Racism sand Related Terms

	Definitions	Notes
Racism	As defined by Camara Jones, MD, MPH, PhD, "racism is a system of structuring opportunity and assigning value based on phenotype ('race'), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and undermines realization of the full potential of the whole society through the waste of human resources."	Racism can operate at different levels: structural, institutional, interpersonal, and internalized.
Structural Racism	As defined by Zinzi Bailey et al, structural racism "refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources."	
Institutional Racism	Discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race.	Individuals within institutions take on the power of the institution when they act in ways that advantage and disadvantage people, based on race.
Interpersonal Racism	The expression of racism between individuals. These are interactions occurring between individuals that often take place in the form of harassing, racial slurs, or racial jokes.	It may also take more subtle forms of unequal treatment, including micro-aggressions.
Internalized Racism	Acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth.	
Prejudice	An unfavorable opinion or feeling formed beforehand or without knowledge, thought, or reason.	Prejudice also means an action in the sense that they are sequential steps by which an individual behaves negatively toward members of another group: verbal antagonism, avoidance, segregation, physical attack, and extermination. The term "prejudice" also refers to unfavorable opinions or feelings which lead groups to view members of other social groups as threatening adversaries who are inherently inferior or are actively pursuing immoral objectives.

Adapted from Lawrence 2004, David Wellman, Jones 2000 and Bailey, et al 2017, Greenwald and Banaji, 1995

	Definitions	Notes
Bias	A form of prejudice in favor of or against one person or group compared with another usually in a way that's considered to be unfair to one group. Biases may be held by an individual, group, or institutions and can have negative or positive consequences and oftentimes are learned behaviors or habitual thoughts. Biases often emerge in relation to race/ethnicity, gender, socioeconomic status, ability status, LGBTQ+ identity, literacy, amongst other groupings. There are two main types of biases[20] discussed in scholarly research and in medicine [21,22] that inhibit progress towards multiculturalism and equity in our society: 1. **Explicit or Conscious bias**—This refers to the attitudes and beliefs we have about a person or group on a conscious level, that is we are aware and accepting of these beliefs, and they are usually expressed in the form of discrimination, hate speech or other overt expressions. 2. **Implicit or Unconscious bias**—This refers to the unconscious mental process that stimulates negative attitudes about people outside one's own 'in group'. For example, implicit racial bias leads to discrimination against people not of one's own group. Extensive research supports the notion that we all hold unconscious beliefs about various social and identity groups, and these biases stem from one's tendency to organize social worlds by categorizing and are influenced by power dynamics in a society.	It is important to note that biases, both explicit and implicit, have to be unlearned at the individual, group and institutional level in order to mitigate negative consequences as a result of existing and prevailing biases. Both first require an awareness and acknowledgment that the bias exists and require personal, group and institutional action to eliminate these biases.

Adapted from Lawrence 2004, David Wellman, Jones 2000 and Bailey, et al 2017, Greenwald and Banaji, 1995

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APPENDIX C: Key Principles and Associated Terms

Table 1: Key Principles and Associated Terms

Key principles	Instead of this . . .	Try this . . .
Avoid use of adjectives such as vulnerable, marginalized and high-risk. These terms can be stigmatizing. These terms are vague and imply that the condition is inherent to the group rather than the actual causal factors. Try to use terms and language that explain why and/or how some groups are more affected than others. Also try to use language that explains the effect (i.e., words such as impact and burden are also vague and should be explained).	• Vulnerable groups • Marginalized communities • Hard-to-reach communities • Underserved communities • Underprivileged communities • Disadvantaged groups • High-risk groups • At-risk groups • High-burden groups	• Groups that have been economically/socially marginalized • Groups that have been historically marginalized or made vulnerable; *historically* marginalized • Groups that are struggling against economic marginalization • Communities that are underserved by/with limited access to (specific service/resource) • Under-resourced communities • Groups experiencing disadvantage because of (reason) • Groups placed at increased risk/put at increased risk of (outcome) • Groups with higher risk of (outcome) • For scientific publications: – Disproportionately affected groups – Groups experiencing disproportionate prevalence/rates of (condition)
Avoid dehumanizing language. Use person-first language instead. Describe **people** as having a condition or circumstance, not being a condition. A case is an instance of disease, not a person. Use patient to refer to someone receiving health care. **Humanize those you are referring to by using people or persons.**	• The obese or the morbidly obese • COVID-19 cases • The homeless • Disabled person • Handicapped • Inmates • Victims • Cases or subjects (when referring to affected persons) • Individuals	• People experiencing (health outcome or life circumstance) • People with obesity; people with severe obesity • Patients or persons with COVID-19 • People who are experiencing (condition or disability type) • Person with mobility disability • Person with vision impairments • People who are experiencing homelessness • Survivors
Remember that there are many types of subpopulations. General use of the term minority/minorities should be limited, in general, and should be defined when used. Be as specific as possible about the group you are referring to (e.g., be specific about the type of disability if you are not referring to people with any disability type).	• Minorities • Minority • Ethnic groups • Racial groups	• Specify the type of subpopulation: – (People from) racial and ethnic groups – (People from) racial and ethnic minority groups – (People from) sexual/gender/linguistic/religious minority groups – (People with/living with) mobility/cognitive/vision/hearing/independent living/self-care disabilities
Avoid saying target, tackle, combat or other terms with violent connotation when referring to people, groups or communities. These terms should also be avoided, in general, when communicating about public health activities.	• Target communities for interventions • Target population • Tackle issues within the community • Aimed at communities • Combat (disease) • War against (disease)	• Engage/prioritize/collaborate with/serve (population of focus) • Consider the needs of/Tailor to the needs of (population of focus) • Communities/populations of focus • Intended audience • Eliminate (issue/disease)
Avoid unintentional blaming. Consider the context and the audience to determine if language used could potentially lead to negative assumptions, stereotyping, stigmatization, or blame. However, these terms may be appropriate in some instances.	• Workers who do not use PPE • People who do not seek healthcare	• People with limited access to (specific service/resource) • Workers under-resourced with (specific service/resource)

Adapted from: "Health Equity Guiding Principles for Unbiased, Inclusive Communication" (CDC).