JOSIAH MACY JR. FOUNDATION

CONFERENCE RECOMMENDATIONS
February 24–27, 2020
Atlanta, Georgia

Addressing Harmful Bias and Eliminating Discrimination in Health Professions Learning Environments

Dear Colleagues:

Not for the first time, Americans are peacefully protesting, calling for an end to structural racism and legalized oppression. The embers of change have been smoldering for decades—they never went away after the 1960s Civil Rights movement—and, in spring 2020, they reignited across the nation.

First, we witnessed a pandemic reaching around the globe, disproportionately affecting low-income populations, particularly people of color, across America. Then came a series of disturbing videos, forcing us to confront the continuing crisis of lethal police brutality wielded, again disproportionately, against unarmed Black people in the United States. Protest movements sprang up in cities and towns across the country and around the world, with the primary message—Black Lives Matter—finding an unreceptive audience in the White House and other parts of the government. These and many other deeply disturbing circumstances have brought us to this time of reckoning.

I can't say what will change as a result. Meaningful justice-system reform? Yes, hopefully. A presidential administration more responsive to the needs and wants of its people? Americans can make that a reality at the polls in November. A health care system that is diverse, equitable, and inclusive? Together, those of us working in the health professions—whether in clinical care, education and training, administration, regulation, licensure, professional associations, philanthropy, etc.—can make that happen. Hopefully, most of us were committed to advancing diversity in health care long before spring 2020, but now we have an unmistakable opportunity to also prioritize equity and inclusion that we must not waste.

As you—my colleagues in health care—continue to think about this issue, I hope that the recommendations outlined in the following conference summary will help. They were developed during and immediately following a conference on *Addressing Harmful Bias and Eliminating Discrimination in Health Professions Learning Environments*, which was convened by the Josiah Macy Jr. Foundation in late February 2020. The summary reflects the discussions that took place during the meeting, before the COVID-19 pandemic and anti-racism protests of 2020 took root. Those events make the recommendations even more relevant and urgent.

As health care leaders and professionals, we have been careful with our words and deeds for too long—careful to use polite language when talking about uncomfortable topics; careful to seek change gradually and bring people along at their own speed; careful to protect the reputation of the world-renowned clinical systems in which we trained and which have done so much good for so many; careful to be respectful of the fact that we have devoted our lives to caring for others. While being polite and doing good, however, we have also enabled injustice to flourish unchecked. We must do better.

In October 2019, the Josiah Macy Jr. Foundation's board of directors ratified a new strategic plan that prioritizes diversity, equity, and belonging in health professions learning environments. Our mission is to improve the health of the public by advancing the education of health professionals, and we recognize that we can do this only by advancing equity for all. Thus, we are committed to advancing racial justice in health care. We recognize that systemic racism and legalized oppression infect all parts of our society, including health care and the clinical learning environments where our future health professionals work and learn. The majority of people in the health professions are White and have benefited from White privilege.

We recognize the efforts of those health leaders, community advocates, and philanthropies who are working to disrupt the status quo. We pledge to amplify their efforts by catalyzing change in clinical learning environments—the field we know best. Our goal is to ensure that everyone who receives care and everyone who learns, teaches, and works in clinical environments is treated equitably and feels a sense of belonging. We will do this through our grantmaking and our conferences—we are already planning a follow-up to the February conference focused on advancing anti-racism and antidiscrimination efforts in health professions learning environments.

We are also sponsoring a special supplement of the journal *Academic Medicine*, dated December 2020, whose contents will include the commissioned papers and case studies from the February conference as well as additional papers on the topic of mitigating harmful bias and reducing discrimination in health professions learning environments.

I hope you will read the conference recommendations with a renewed sense of the insidious injustices that people of color face every day in America. Now is the time not only to acknowledge the racism and resulting inequities in our health care system, but to act.

Sincerely,

Holly J. Humphrey

Holly J. Humphrey, MD, MACP
President

Consensus Vision Statement

Our nation's health professions learning environments—from classrooms to clinical sites to virtual spaces—should be diverse, equitable, and inclusive of everyone in them, no matter who they are. Every person who works, learns, or receives care in these places should feel that they belong there.

The imperative to advance diversity[1] in the US health care workforce is widely accepted, and exemplary stories of success can be found in some corners of our health system, but overall progress has been slow. This is evidenced by the low numbers of people from historically underrepresented populations enrolling in health professions schools and joining the health professions workforce, ongoing reports of bias and discrimination in health professions learning environments, and a continuing dearth of proven and replicable best practices to advance diversity. Many of our health professions schools and clinical practice sites are taking some action on diversity and the more contemporary concepts of equity and inclusion, but without making the necessary commitment to comprehensive, system-wide approaches that create meaningful culture change. As a result, addressing harmful bias and eliminating discrimination remain critical challenges to achieving excellence in health care and health professions education.

The nation's demographics are changing rapidly. Judging from trends in the US Census, in the next 20 to 25 years, America's population will continue to increase, grow older, and become more diverse. As this shift occurs, our health professions learning environments can do a better job of producing health care professionals who are reflective of, and sensitive to, the needs of the communities they serve, especially those community members who are the most vulnerable among us. This imperative seems particularly urgent now, given the pervasiveness of inequities in health, which have been thrown into stark relief most recently by the COVID-19 pandemic. Infection and death rates are disproportionately high among some historically marginalized and excluded population groups in the US, including the African American, American Indian, and Latinx populations (CDC 2020).

Advancing diversity, equity, and inclusion within and across the health professions is the right thing to do in a nation that, for far too long, has protected privilege and tolerated racism and other exclusionary "-isms," including sexism, ableism, ageism, heterosexism, and classism. Advancing an agenda of diversity, equity, and inclusion within the health professions is central to improving overall well-being in the US and reducing attrition among historically underrepresented populations in health professions schools and professional practice. Further, we must advance diversity, equity, and inclusion in the health professions because they are crucial to the delivery of high-quality, patient-centered care that addresses the social determinants of health, reduces persistent health care inequities, and fosters trust between clinicians and patients.

The Physician Charter on Medical Professionalism (ABIM Foundation 2002), the Charter on Professionalism for Health Care Organizations (Egener, et al. 2017), the American Association of Colleges of Nursing (AACN), and the Association of American Medical Colleges (AAMC) all embrace the need to advance social justice, diversity, equity, and inclusion within their professions. AACN, for example, views it as a high priority, stating: "Nursing's leaders recognize a strong connection between a culturally diverse nursing workforce and the ability to provide quality, culturally competent patient care. Though nursing has made great strides in recruiting and graduating nurses that mirror the patient population, more must be done before adequate representation becomes a reality. The need to attract students from underrepresented groups in nursing—specifically men and individuals from African American, [Latinx], Asian, American Indian, and Alaska native backgrounds—is a high priority for [the] nursing profession" (AACN 2019). Further, these more representative students must become the faculty workforce of the present and future.

The AAMC, for its part, has said, in a statement on gender equity in medical education: "The AAMC acknowledges that gender equity is a key factor in achieving excellence in academic medicine. To achieve the benefits of diversity, [it] must be inextricably linked to inclusion and equity. Environments are equity-minded when every person can attain their full potential and no one is disadvantaged from achieving this potential by their social position, group identity, or any other socially determined circumstance. AAMC member institutions must be intentional in identifying exclusionary practices, critically deconstructing the practices that sustain inequities within our institutions and acting to eliminate these inequities" (AAMC 2019a).

Conference Tackles a Complex Challenge

Leaders, faculty, clinicians, and learners in both health care delivery and health professions education organizations have long known that increasing diversity among health professionals is important. They also know that efforts focused simply on recruiting more people from diverse population groups have not worked; instead, advancing diversity, equity, and inclusion must become an institutional priority, integrated into the mission (Thomas, Ely 1996). A longitudinal look at the demographics of the nation's health professions faculty, clinician, and student populations demonstrates how difficult it has been to move the needle on increasing representation among the groups that historically have been the most marginalized.

[1]See glossary for brief definitions of terms related to diversity, equity, inclusion, bias, and discrimination used in this report.

Within the registered nurse (RN) workforce, according to the National Council of State Boards of Nursing (NCSBN), 81% are White/Caucasian (vs 60% of the US population), while 19% of nurses are from underrepresented racial/ethnic populations, including: Black/African American (6.2%), Asian (7.5%), Latinx or Hispanic (5.3%), American Indian/Alaska Native (0.4%), and Native Hawaiian/Pacific Islander (0.5%). With respect to gender diversity, 9% of RNs are men (Smiley et al. 2017). In medicine, according to the AAMC, female matriculants at US medical schools now outnumber male students 50.5% to 49.4%, and 25% of matriculants are Asian students (Boyle 2019, AAMC 2019b). However, the number of Black students, particularly Black men, has essentially stagnated. According to the AAMC, in 1978, there were 542 Black male matriculants to MD-granting institutions in the US, and in 2019, that number had only increased by 77, to 619 (Gallegos 2016, AAMC 2019b).

And, while the statistics for Black men in medicine are troubling and have been intractable to date, even the news that more women than ever before are enrolled in US medical schools is tempered by the fact that they remain underrepresented in multiple specialties as well as in leadership positions at medical schools and health care delivery organizations. According to a 2019 *Modern Healthcare* article, for example, women compose about 80% of the American health care workforce, but they lead fewer than 20% of US hospitals. The numbers for Black women are worse.

These few pieces of data provide only a very narrow glimpse into diversity in the health professions. True diversity is inclusive of any and all possible voices and perspectives. In addition to race, ethnicity, and gender, a few of the many other personal and social identities on which data are collected include differences in abilities, age, socioeconomic status, gender identity and expression, sexual orientation, familial status, religion, legal status, military service, political affiliation, and geographic origin. Data related to diversity are also difficult to track accurately because some possibly stigmatizing traits that might trigger discrimination—mental health issues or learning differences, for example—may be kept hidden.

Often used interchangeably, bias and discrimination refer to two sides of the same prejudicial coin that, together, result in health professions learning environments that stifle diversity, equity, and inclusion. Harmful bias and discrimination have been identified as significant contributors to health disparities among patients as well as to attrition among underrepresented populations in health professions schools and professional practice, and it is important to tackle these problems (Mateo, Williams 2020).

To immediately accelerate long-needed action in this area, the Josiah Macy Jr. Foundation hosted a conference, originally titled *Addressing Bias and Reducing Discrimination in Health Professions Learning Environments*. Held February 24–27, 2020, in Atlanta, Georgia, the conference convened more than 40 invitees, including deans of medical and nursing schools, faculty and clinician leaders, representatives from health professions organizations, health professions trainees and students, and others who have worked to advance diversity in the health professions. In addition to inviting conferees with knowledge and expertise related to the conference topic, the organizers made sure that the conferees represented a wide range of backgrounds, perspectives, and personal and professional experiences.

In her welcoming remarks to conferees, Macy Foundation President Holly Humphrey stated her "two straightforward but not easy goals for this conference where we are tackling a very complex topic: first, I hope we find ways to create a sense of belonging for everyone within our health professions learning environments, and second, I want us to develop actionable recommendations to address bias and reduce discrimination in those environments."

Conference Overview

Prior to the conference, invited participants read four Macy-commissioned papers and three case studies, all focused on addressing bias and reducing discrimination in health professions learning environments.[2] On the first day of the conference, the authors of the papers and case studies presented overviews of their work. These materials, summarized briefly below, established the baseline from which the conferees launched their discussions and began to consider actionable recommendations to address bias and reduce discrimination in health professions learning environments.

Commissioned Papers Provided Basis for Discussion

The paper "More Than Words: A Vision to Reduce Bias and Discrimination in Health Professions Learning Environments," by Camila Mateo of Harvard Medical School and Boston Children's Hospital and David Williams of the Harvard School of Public Health, outlined a framework of evidence-based approaches that institutions can use to reduce bias and discrimination. According to the paper, "Addressing bias and discrimination can be daunting, but through deliberate and systemic change we can reduce their effects and promote the growth and well-being of individuals on both sides of the stethoscope." The paper stated that there is more evidence on how to reduce bias and discrimination than most health professionals realize.

The authors described a vision for the future in which health care learning environments are deliberately structured to reduce bias and discrimination across institutional, interpersonal, and individual levels through leadership, accountability, resource allocation, and data-driven interventions that are continually evaluated for their effectiveness in reaching measurable goals over time. Achieving this vision, they said, requires the following:

- Systems to assess and address the current state of bias and discrimination throughout the institution
- Reduction of harmful bias and discrimination as an institutional priority
- Comprehensive curricular offerings throughout the institution explicitly aimed at reducing harmful bias and discrimination
- Increased representation of underrepresented backgrounds in trainee, faculty, and leadership positions
- Institutional culture of respect, inclusion, and equity for all members

[2]Materials will be published in full in a special supplement of Academic Medicine in December 2020. The supplement is expected to be available online in fall 2020 via the journal's website. The papers will also be published as part of the Macy Foundation's conference monograph.

At the conference, Mateo briefly walked through some of the ways these recommendations can be implemented. She said that achieving equity for underrepresented population groups in opportunities and representation may be the most important of the recommendations because, as the paper states: "Creating a workforce that reflects the broad diversity of current patient populations is one of the most powerful ways to reduce bias and discrimination within the health professions. . .Despite this, there has been little improvement in representation in the health care workforce."

According to the authors, the most effective way to increase representation is by assigning responsibility for meeting set diversity goals: "We recommend that institutions assign responsibility of demonstrating measurable change to managers, whether through a task force, leadership position, the establishment of an office dedicated to this work, or a combination of the above," the paper states. The paper explains that a comprehensive, long-term study comparing different strategies found this one to be the most effective at improving the diversity of organizations. It also enhanced the effectiveness of other diversity-focused strategies.

In "Addressing Patient Bias and Discrimination Against Clinicians of Diverse Backgrounds," authors Pooja Chandrashekar of Harvard Medical School and Sachin Jain of Stanford University School of Medicine described the ways bias and discrimination harm the patient-clinician relationship—specifically, the "less-studied and particularly complex" issue of patient bias and discrimination toward clinicians. The paper included frameworks for individual clinicians to use when faced with patient bias and discrimination and also discussed what is needed at the institutional level to address this issue.

"Clinicians work in a service industry with an implicit expectation to care for patients regardless of their behavior; the patient's right to receive care overrides everything else," said Chandrashekar when presenting the paper. "But clinicians also have the right to work without fear of being abused and the right to be treated with dignity and respect. Today, there is little explicit support for balancing the rights of patients and clinicians when they are in conflict."

The paper argued that this issue should not be ignored because it has short- and long-term negative effects on clinicians and patients. On the clinician side, researchers have found that people who are targets of discrimination and other forms of prejudice have higher rates of anxiety, depression, high blood pressure, and cardiac disease. Further, the emotional burden of caring for patients who express harmful biases can be substantial and is associated with symptoms of psychological decline as well as professional burnout, which has been on the rise among health professions clinicians and learners even before the COVID-19 era and is a major concern (NAM 2019). On the patient side, anecdotal evidence suggests that clinicians are less inclined to spend extra time with patients who express bigoted views, which may affect the quality of the care these patients receive.

The authors suggested a framework that clinicians may use when caring for a patient who is expressing harmful views or exhibiting discriminatory conduct. They also suggested ways to apply this framework depending on the following circumstances: when a patient is requesting a different clinician, when a patient is actively exhibiting discriminatory behavior, when trainees are the target of the harmful patient behavior, and when a non-targeted bystander witnesses such behavior.

When responding to discriminatory patient behaviors, for example, the authors suggested that clinicians first ensure their own safety, asking themselves, "Do I feel safe caring for this patient?" If the answer is no, it is the clinician's right to exit the patient encounter, seek help from colleagues or a supervisor, report the incident, and consider transferring care to another clinician. While assessing their own safety, clinicians should also assess the patient's condition—is the patient in urgent need of care? In an emergency situation, it may be necessary for a clinician who feels unsafe to treat and stabilize the patient before transferring care.

If the clinician feels safe and the patient is stable, the clinician should assess the patient's motivations. The authors suggested "intentionality" as "a useful heuristic for determining whether a patient's biased behavior should be tolerated: do they convey an intent to hurt or shame the targeted clinician?" Sometimes the behavior might have a different motivation, such as prior trauma (e.g., a rape victim expressing fear). When patients appear to be motivated by prejudice, however, clinicians are within their rights to express discomfort. The authors concluded: "When a patient's views interfere with the clinician's well-being or preclude the clinician from delivering good medical care, it may be best to reassign the patient." Following incidents like these, clinicians should inform their supervisors, report the incident, and consider documenting it in the patient's chart (after weighing the severity of the incident and how the patient's care could be affected). Clinicians should be given time and space to thoroughly debrief after such incidents.

Finally, the authors suggested institutional-level strategies for addressing patient bias toward clinicians. These include making patients aware of the institution's commitment to diversity and inclusion and developing and disseminating guidelines for appropriate patient conduct and/or a list of patients' and clinicians' rights. Further, institutions should develop explicit policies and procedures for addressing these situations, including reporting mechanisms and systems to adjudicate cases of bias. The authors also called for more systematic research into the topic.

Authors from the University of Virginia (UVA) School of Medicine—Margaret Plews-Ogan, Taison Bell, Gregory Townsend, Randolph Canterbury, and David Wilkes—wrote about wisdom as a counterbalance to bias. In "Acting Wisely: Toward Eliminating Negative Bias in Medical Education," the authors described the problems that harmful biases and discrimination create in medical education, in the medical profession, and for patients. They offered a wisdom-based framework for understanding and mitigating the effects of negative biases and turning them into positive biases.

In her presentation at the conference, Plews-Ogan explained: "I study wisdom, specifically how it develops from experiences of adversity. And, in Charlottesville, Virginia," the home of UVA and the site of a violent and deadly White supremacists' march in 2017, "in the last few years, we have had more than ample opportunity to work on developing wisdom around racism."

She defined wisdom as well as what it means to make wise decisions and to act wisely. Making wise decisions

involves intellectual humility, recognizing uncertainty, seeking others' perspectives, and integrating those perspectives into decision-making. Acting wisely encompasses not only awareness, but also the exercise of affective and cognitive control over one's actions. According to the paper, "Making wise decisions and acting wisely is more likely in an environment that facilitates these affective, reflective, and cognitive capacities; an environment that is aware of biases, that strives to mitigate negative biases, and to create a platform for human interaction that positively predisposes us toward one another."

"Acting wisely," Plews-Ogan said, "involves intention, will, and the skill to do the right thing—it is not easy. It requires some fundamentals, including deep knowledge about what biases are and where they come from, their historical contexts as well as skills like awareness, compassion, humility, and reflection." The paper deeply explored all of these components.

The paper also laid out a set of actions—interpersonal, structural, and cultural—that can be taught and employed to increase "wise actions" in health professions learning environments. Interpersonal actions include training in how to mitigate our own implicit biases; building awareness and acceptance of the reality of explicit bias; and "stepping in," saying or doing something that can begin to change a situation for the better. According to the paper, a team at UVA "has developed a training program, using videos depicting scenarios of explicit bias . . . that gives participants a framework for responding to bigotry and prejudice in the training environment."

Structural actions include increasing the diversity of positive role models and clinical learners as well as creating reporting resources, standing rules, and policies that support the institution's commitment to diversity and to addressing bias and discrimination. Among the cultural actions described in the paper are setting expectations for diversity, inclusion, and respect; establishing personal accountability; and "nudging." According to the paper, "Nudging means understanding how we think, how we choose what to perceive, and how we can influence one another to do better, including how we can use social influence within the training community to 'nudge' people toward being better."

Finally, "Medical Education's Wicked Problem: Achieving Equity in Assessment for Medical Learners," by Catherine Lucey, Karen Hauer, and Alicia Fernandez of the University of California, San Francisco School of Medicine, and Dowin Boatright of the Yale School of Medicine, examined inequities in the assessment of medical students. The authors noted that "many medical schools have successfully used holistic admissions strategies to increase diversity in their classes," but students in these more diverse classes "have observed that similar increases in diversity have not been seen in honor societies, selective residency programs, and medical specialties, and among faculty in US medical schools." The authors posited that, since entry into competitive programs and careers is often dependent on grades and academic awards, there is reason to be concerned about the impacts of structural and interpersonal bias on medical school assessment practices.

Referring to inequities in assessment as a "wicked" (meaning complex and solution-resistant) problem, the authors suggested that addressing the issue "will require concerted work by educators in all medical schools and residency programs" (and educators in all other health professions). They described key concepts and examined the literature on equity in medical education assessment. They defined equity as being "present when all students have fair and impartial opportunities to learn, and be evaluated, coached, graded, advanced, graduated, and selected for subsequent opportunities based on their demonstration of achievements that predict future success in the field of medicine and [when] neither learning experiences nor assessments are negatively influenced by structural or interpersonal bias related to personal or social characteristics of the learner or the assessor."

The authors suggested that there are three components to equity in assessment: 1) intrinsic equity, which means that the design of the assessment program and the tools it uses minimize bias against groups who have been historically marginalized by the medical profession; 2) contextual equity, which refers to fairness in the learning experience and environment in which assessment strategies are implemented; and 3) instrumental equity, which means that the assessment results are shared with and used by stakeholders in ways that create equitable opportunities for all. These three types of equity "collectively contribute to equity in assessment outcomes: the opportunities that are afforded to individuals and populations are based on the consequences of assessment."

Because their literature review substantiated concerns about equity in medical education assessments, the authors suggested a framework for creating equity in assessment. This framework, which is based on the Shingo Model for organizational and operational excellence,[3] holds that achieving equity in medical education assessment requires:

- A nationwide commitment to advancing equity as an essential element in health care and medical education
- Recalibration of long-standing beliefs (culture) about the ways in which we define, develop, and recognize excellence in medicine
- Assessment systems designed to support intrinsic, contextual, and instrumental equity
- Assessment tools that support equity
- Process and outcome indicators that indicate equity in assessment

In addition to the four papers summarized above, conferees also read case studies featuring efforts to address bias and reduce discrimination at two medical schools (Morehouse School of Medicine and Washington University School of Medicine) and one nursing school (University of Cincinnati College of Nursing). These case studies described various ongoing institutional approaches to mitigating harmful bias and eliminating discrimination. Morehouse School of Medicine focused its case study around efforts to remove bias and discrimination from the teacher-learner relationship, while Washington University School of Medicine described a process for understanding and addressing bias in clerkship grading. The University of Cincinnati College of Nursing assessed diversity within the school and used the findings to introduce programming focused on increasing enrollment, presence, inclusion, and success of students from underrepresented population groups.

In addition to engaging with the commissioned papers and case studies, conferees were asked to provide feedback on a draft vision statement prepared by the conference planning committee. The draft was found to be too long and not well focused. A review and revision

[3] *https://shingo.org/shingo-model/*

process began at the conference and continued via email afterward. The final vision statement for the future of health professions learning environments appears at the beginning of this document.

Themes from Conference Discussions

During the first full day of the conference, the authors presented summaries of their commissioned papers and case studies, which became the subject of breakout group and plenary discussions. The second full day brought several themes into focus as the conferees concentrated on developing a consensus vision statement and recommendations.

A significant theme of the conference was intersectionality. The discussion around this topic could easily have caused conferees to retreat from meaningful discourse, but instead it culminated in a difficult but open, thoughtful, and respectful exchange. Intersectionality is a concept originated by the legal scholar and civil rights activist Dr. Kimberlé Crenshaw, who described it as "a lens through which you can see where power comes and collides, where it interlocks and intersects. It's not simply that there's a race problem here, a gender problem here, and a class or LGBTQ [lesbian, gay, bisexual, transgender, queer] problem there. Many times, that framework erases what happens to people who are subject to all of these things" (Crenshaw 1989, 2017).

During a plenary discussion, a group of conferees suggested that recommendations to advance antibias and antidiscrimination efforts in health professions learning environments should focus on America's history of racism targeting Black people and American Indians. While they recognized the many other forms of structural oppression, they felt strongly that the historical context of America's system of oppression should be stressed in the recommendations. Another group, however, warned against appearing to advance the idea that there is a hierarchy of oppression. They felt strongly that focusing on the history of racism in the recommendations without giving weight to other forms of discrimination would minimize centuries of pain experienced by other marginalized and excluded groups, including women, the LGBTQ community, people living with disabilities, people living in poverty, religious minorities, and other racial and ethnic groups.

Many important points, all revealing the complexity of intersectionality, were made during this discussion. One conferee offered insight from her own experiences as a medical school diversity officer: "This is difficult stuff to talk about, but it is critical pedagogy. We used to teach about social determinants and health disparities without providing context for where these things came from and why they persist. But now we do more on that. Understanding power and privilege is necessary. Knowing the history of racism is important. We do spend some time on understanding our own biases, but we spend more time on cognitive dissonance and our shared identities as providers within a larger system whose history we need to understand so that we can do better."

Another conferee reminded their colleagues in the room that, while there are tremendous data resources available on the harms created by racism over hundreds of years, there are very few on transgender people. "We know that [transgender people are] dying at atrocious rates and that they're not becoming health professionals," they said, "but we need to know much more." Similar calls for a broader conception of discrimination came from conferees who identified other historically marginalized and excluded groups. At one point, Macy President Humphrey reminded attendees that many marginalized voices were missing from the conference, even though the organizers did their best to include as many as possible. Humphrey wished, for instance, that international health professions students were in the room.

Another theme that resonated throughout the meeting was the need for this work to take root at the structural and systems levels rather than being implemented piecemeal within the individual institutions where health professions learning environments are found. As a conferee said, "We need to focus on systems change, on structural change. It is not enough to address discrimination when we see it. We need to replace a system that was designed to be unfair with a system that protects, respects, and values vulnerable patients, students, faculty, and others. If we want to build a socially responsible workforce, we all need to understand the deeply entrenched barriers that people face working, learning, and seeking care in our health system. It goes beyond our health professions schools and delivery organizations. We need organizations like the ACGME [Accreditation Council for Graduate Medical Education], LCME [Liaison Committee on Medical Education], CCNE [Commission on Collegiate Nursing Education], ACEN [Accreditation Commission for Education in Nursing], NLN [National League for Nursing], AACN, AAMC, and all the other groups that have a role in incentivizing and rewarding our health professions institutions for serving the public good to commit to changing the system."

While conferees seemed to agree that structural change across the entire health care system is needed, they also agreed that, at individual institutions, this work will have to take root in the board room and C-suite in order to create culture change. Trustees and executive leaders will need to set expectations and model appropriate behaviors, such as a personal awareness of their own biases, zero tolerance for discrimination, and support for civil discourse. They will also need to hold themselves and their staff accountable for achieving measurable changes related to diversity, equity, and inclusion. "I have served at every level of academia, and I am very clear that efforts to advance diversity in the health professions must start with CEOs and their executive leadership," said a conferee. "We haven't seen the needle move much at all over the years, even though most medical schools, including the 15 newest ones, name diversity and inclusion in their mission statements. Diversity is a desired outcome, but it's not being achieved. We need to start holding leaders accountable."

Holding leaders accountable for achieving desired outcomes, however, requires giving them access to the kinds of research and data needed to develop, implement, and evaluate efforts to advance diversity, equity, and inclusion. Many conferees called for funders to support research, for institutions to collect and share more data, and for the creation of a national interprofessional resource center or other entity to coordinate research and disseminate best practices.

Conferees expressed the need for common language or an agreed-upon lexicon around the topic of diversity, equity, and inclusion. Many raised this point when they stood up to speak about something else, acknowledging that the language being used in the room likely meant different things to different

people and that a common language would go a long way toward advancing the conversation. A simple example: the planning committee titled the conference "Addressing Bias and Reducing Discrimination in Health Professions Learning Environments," but conferees quickly recommended the bolder and more precise "Addressing Harmful Bias and Eliminating Discrimination in Health Professions Learning Environments."

A few conferee quotes capture the various points made about language:

- "The language that we use is important. But do we use the language that helps people clearly link what happened historically to what is happening now? Do we call it racism and talk plainly about the history of American slavery and Jim Crow laws? Or do we use post-racism language and call it implicit bias so that people will be comfortable? Can we develop a common language?"
- "We have to admit that racism exists. It's not just bias, but we sometimes call it that just to get a message out so that people won't shut down when they hear it."
- "Not using the correct language in conversations around this work means that the oppressed people in the room immediately say to themselves, 'I need to make the other people in this room, the majority people, feel good while having this discussion, regardless of what I feel.'"

A point that cropped up repeatedly was that effective incentives are needed in order to make progress in advancing diversity, equity, and inclusion—and ineffective incentives should be removed, neutralized, or ignored. As one commenter said, "We need to take false incentives—like *U.S. News & World Report* rankings . . . and other things that don't speak to the quality of our institutions—off the table. They undermine the work we do. We have to get our deans to not care about those sorts of measures and start caring about ones that do matter—such as diversity—when it comes to creating excellence in our learning environments and in health care."

Another theme was the fact that, in our health professions learning environments, the implementation of interprofessional education training and coursework creates a valuable opportunity to also prioritize diversity, equity, and inclusion, and vice versa. The two pursuits are closely related, with each seeking to engage faculty and learners in understanding and valuing the perceptions, knowledge, and expertise that come from having different perspectives, experiences, and backgrounds.

As mentioned above, the second full day of the conference was devoted to continuing the discussions from the previous day, but with the specific objective of identifying and drafting actionable recommendations to mitigate harmful bias and eliminate discrimination in health professions learning environments. The conferees worked in breakout groups, which were charged with identifying recommendations within one of four broad areas. These areas were defined by the conference planning committee, which had combined the five recommendation areas contained in the commissioned paper by Mateo and Williams into the following:

- Build an institutional culture of fairness, respect, and anti-racism by making diversity, equity, and inclusion top priorities.
- Develop, assess, and improve systems to mitigate harmful biases and eliminate racism and all other forms of discrimination.
- Integrate equity into health professions curricula, explicitly aiming to mitigate the harmful effects of bias, exclusion, discrimination, racism, and all other forms of oppression.
- Increase the numbers of health professions students, trainees, faculty, and institutional administrators and leaders from marginalized and excluded populations.

As with the consensus vision statement, a review and revision process involving the conferees and the conference planning committee was launched in person at the conference and continued via email afterward. The final consensus recommendations follow. They include specific action steps that every institution should take to advance the recommendations. These recommendations were identified as immediate priorities by the conferees, who also understand that there are a whole host of other actions that an institution can and should undertake to improve diversity, equity, and inclusion.

Conference Recommendations

RECOMMENDATION #1:

BUILD AN INSTITUTIONAL CULTURE OF FAIRNESS, RESPECT, AND ANTI-RACISM BY MAKING DIVERSITY, EQUITY, AND INCLUSION TOP PRIORITIES

Governing board members/trustees and executive leaders of health professions education institutions, health care delivery organizations, and clinical teaching sites should prioritize the mitigation of harmful bias and elimination of discrimination in learning environments by making bold changes that challenge the status quo. Institutional leaders should make the case to members of their oversight boards that achieving diversity, equity, and inclusion is in the best interest of the institution because it enhances the institution's ability to achieve its mission and goals. Leaders should be held accountable for achieving time-sensitive, measurable goals related to diversity, equity, and inclusion. They should promote and prioritize a culture of respect and psychological safety throughout the institution. This will require acknowledging and addressing the pervasive harm that the structural oppression of marginalized and excluded populations has caused and continues to cause in their institutions and across the entire system of health care.

Action Steps

1.1) Governing board members and executive leadership teams should participate in evidence-based trainings and other programming to gain the foundational knowledge and tools needed to effectively commit to, prioritize, and advance diversity, equity, and inclusion across their institutions.

1.2) Governing board members should demonstrate their commitment to advancing diversity, equity, and inclusion by increasing board representation from historically marginalized groups and ensuring that board composition is reflective of both their workforce and patient populations. Governing boards should also carefully evaluate existing and new institutional partnerships to ensure alignment

with the vision for diversity, equity, and inclusion.

1.3) Executive leaders should create, publicly commit to, and widely promote multi-year strategic plans (including concrete, actionable items and evaluation plans) focused on prioritizing the mitigation of harmful bias and elimination of discrimination throughout their institutions. Such plans establish expectations for a culture of diversity, equity, and inclusion.

1.4) Leaders should support and fund the development, implementation, and evaluation of trainings and other programming related to the advancement of diversity, equity, and inclusion for faculty, staff, and other members of their institutional communities. This should include training in advocating for patients, colleagues, trainees, and others—including themselves—who face harmful bias and discrimination in the learning environment. Critical skills include managing microaggressions, conflicts, charged conversations, and discrimination in respectful, psychologically safe ways.

1.5) Leaders should be held accountable for tracking, studying, and reporting—externally and internally—on equity metrics while ensuring the privacy of individuals throughout this process.

1.6) Leaders of health professions schools should employ existing mechanisms and/or develop new ones to incentivize clinical training sites to prioritize diversity, equity, and inclusion.

1.7) Leaders should develop policies and procedures that clearly state behavioral expectations reflective of diverse, equitable, and inclusive learning environments. This includes developing standards of professionalism for their institutions. It also includes a fair and transparent process for handling complaints of harmful bias and discrimination. If such policies and procedures already exist, they should be widely promoted.

1.8) Deans should hold administrators, chairs, and faculty members accountable through mandatory diversity, equity, and inclusion initiatives tied to performance evaluation, compensation, promotion, and rewards (or awards for leadership around diversity, equity, and inclusion). Requirements should be structured to avoid exacting a "minority tax," where an institution's administrators and faculty members from historically marginalized population groups are expected to assume a disproportionate share of diversity-related responsibilities as mentors, committee members, community representatives, etc.

1.9) Federal and state bodies—such as the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, and state health departments—should prioritize and expand research agendas that support the advancement of diversity, equity, and inclusion.

1.10) Health professions' accrediting bodies—such as the Joint Commission, ACGME, LCME, ACEN, and CCNE—should ensure institutional accountability by incorporating and reporting on metrics and programs that help to advance diversity, equity, and inclusion.

1.11) Foundations and/or other entities should allocate resources to the National Academy of Medicine (and/or other appropriate organizations) to develop an evidence-based scorecard that reflects success in advancing diversity, equity, and inclusion at health professions education and health care delivery institutions (similar to the Human Rights Campaign's Healthcare Equality Index or the American Nurses Credentialing Center's Magnet Recognition Program).

1.12) Leaders should ensure visual representation of historically marginalized groups in their institution's physical, visual, and virtual spaces (e.g., portraits and other wall art, TV commercials and promotional brochures, websites). It is important for such efforts to avoid "tokenism" and to genuinely reflect an institution's commitment to advancing diversity.

RECOMMENDATION #2:

DEVELOP, ASSESS, AND IMPROVE SYSTEMS TO MITIGATE HARMFUL BIASES AND TO ELIMINATE RACISM AND ALL OTHER FORMS OF DISCRIMINATION

All health care delivery organizations and health professions education institutions include myriad systems whose assessment and improvement are essential to achieving goals related to diversity, equity, and inclusion. These systems include governance, recruitment, academic evaluation, promotion and advancement, resource allocation, compensation, recognition, communication, the physical environment, patient experience, and the measurement and improvement processes themselves. Leaders of health care delivery organizations and health professions education institutions should intentionally design and continuously improve all of their systems with a focus on advancing diversity, equity, and inclusion—and with recognition that new systems may need to be developed. They should also leverage advances in digital technology to support the use of comprehensive, high-quality data on diversity, equity, and inclusion as institutional key performance indicators.

Action Steps

2.1) Leaders of health professions schools should review their technical standards for learner performance, ensuring that they reflect a commitment to diversity, equity, and inclusion. These standards should seek equity in learning environments for health professions students who are living with disabilities. On academic health center campuses, this should be an interprofessional effort (i.e., it should engage all health professions schools in updating technical standards across the board).

2.2) Leaders of health professions schools and health care delivery organizations should identify key process and outcomes metrics for all organizational and programmatic systems that drive the culture and climate toward diversity, equity, and inclusion.

2.3) Leaders should use common tools to regularly measure (quantitatively and qualitatively) and analyze their culture and climate with respect to

diversity, equity, and inclusion. This includes developing, implementing, and evaluating systems that track complaints and resolutions related to harmful bias and discrimination. These systems should be structured to ensure due process, fair treatment, and physical and psychological safety for everyone involved.

2.4) Leaders should develop limited data-sharing partnerships with health professions organizations that already collect data—such as AAMC, ACGME, NCSBN, NLN, AACN, CCNE, the American Medical Association, the American Nurses Association, and the Coalition of Urban Serving Universities—to ensure that data relevant to diversity, equity, and inclusion goals are gathered and shared.

2.5) Leaders should be held accountable for institutional performance related to diversity, equity, and inclusion goals and outcomes, which should be tied to their own performance evaluations. Similarly, leaders should ensure integration of high-quality data on diversity, equity, and inclusion with other key quality performance indicators (finance, quality, safety). Diversity, equity, and inclusion are inextricably linked with both quality and safety.

2.6) Leaders of institutions and professional organizations should be required to transparently report to both internal and external audiences on initiatives designed to improve diversity, equity, and inclusion as well as related metrics.

2.7) Leaders should collect and analyze reliable quantitative and qualitative patient data with respect to diversity, equity, and inclusion. For qualitative data, interviews, focus groups, and social media using natural language processing and other novel tools for analysis should be used to determine the lived experiences of different patient populations.

2.8) Data scientists and technology experts who can build robust platforms to support development, analysis, and presentation of high-quality data relevant to diversity, equity, and inclusion should be members of health professions education teams. Together with their teams, they should develop ways of assessing (such as through predictive analytics) the likely impact of proposed program changes on equity, diversity, and inclusion. If such technical expertise is not available locally, it should be sought out.

2.9) Data designed to track and analyze efforts to advance diversity, equity, and inclusion and to mitigate harmful bias and eliminate discrimination must protect the privacy and safety of individuals; data that lack such protections may not be representative if there are real or perceived reporting barriers.

RECOMMENDATION #3:

INTEGRATE EQUITY INTO HEALTH PROFESSIONS CURRICULA, EXPLICITLY AIMING TO MITIGATE THE HARMFUL EFFECTS OF BIAS, EXCLUSION, DISCRIMINATION, RACISM, AND ALL OTHER FORMS OF OPPRESSION

Leaders of health professions education institutions—including deans, curriculum directors and developers, and faculty—should ensure that required health professions curricula examine the harm caused by bias, exclusion, discrimination, and all forms of oppression. This means teaching health professions learners (and training faculty in how to teach learners) about the lasting negative impacts on people's health and opportunities wrought by slavery, genocide, and eugenics; legalization of racism, sexism, anti-Semitism, Islamophobia, and homophobia; and medical pathologizing of homosexuality and gender diversity. The affected population groups include but are not limited to Black people, Latinxs, Native Americans, women, LGBTQ community members, people living with disabilities, people living in poverty, and religious minorities.

All health professions leaders, faculty, staff, and learners should demonstrate competence in promoting diversity, equity, and inclusion in the learning, workplace, and patient care environments. This competence should include knowledge of the historical context and maintenance of America's deeply entrenched system of structural oppression, which contribute to today's health inequities, inequalities, and disparities. America's health professionals should understand how their personal and social identities significantly influence their patients' health as well as their own and their colleagues' opportunities in the health professions.

Action Steps:

3.1) Accrediting bodies should require all health professions schools to conduct and make transparent a rigorous and holistic self-study of their institutional histories that have positively and negatively affected curricula, the learning environment, and patient care.

3.2) Health professions education institutions should, in the spirit of continuous quality improvement, regularly assess learning environments and programs for evidence of harmful bias and discrimination, using learner feedback as a critical source of information.

3.3) Health professions schools should co-create with their communities both educational and experiential opportunities to help learners understand the places where their patients live, work, learn, and play.

3.4) Foundations or other funders, together with health professions schools, should create an interprofessional training program or institute for educators and administrators to learn about and develop robust curricula around mitigating harmful bias and eliminating discrimination (modeled, for example, on the Harvard Macy Institute: harvardmacy.org).

3.5) Foundations or other funders should support the development of a curriculum that has demonstrated effectiveness in helping learners, leaders, and members of the health professions workforce manage (in real time) bias and discrimination in clinical learning environments, including bystander training—and institutions should mandate participation.

3.6) Health professions schools should transform their admissions guidelines to require applicants to demonstrate awareness of, interest in, or aptitude in the knowledge, skills, and attitudes that promote diversity, equity, and inclusion

3.7) Health professions schools should require learner participation in a formal health disparities curriculum and encourage faculty to incorporate health disparities content throughout their curricula. They should also undertake a thorough review of existing curricula across all subject areas to identify and eradicate racialized content, such as stereotypes that perpetuate harmful bias and discrimination. Such content should be replaced by material that promotes equity, inclusion, and diversity, such as anti-racism training.

3.8) Health professions schools should develop and incorporate learner assessment systems that measure competence in the knowledge, skills, and attitudes that promote diversity, equity, and inclusion.

3.9) Health professions schools should conduct fair and equitable assessments of their learners. Schools should adopt a system of learner assessment that seeks to mitigate harmful bias and provide frequent feedback, coaching, and transparency in order to support mastery learning and growth mindsets. Health professions leaders should also advocate on the national level for development and use of fair and equitable assessment tools.

RECOMMENDATION #4:

INCREASE THE NUMBERS OF HEALTH PROFESSIONS STUDENTS, TRAINEES, FACULTY, AND INSTITUTIONAL ADMINISTRATORS AND LEADERS FROM HISTORICALLY MARGINALIZED AND EXCLUDED POPULATIONS

Health system and health education leaders should commit to increasing the numbers of students from underrepresented populations entering and graduating from health professions schools. They should also develop pathways to recruit, retain, and advance opportunities for underrepresented faculty. Further, leaders should innovate processes to encourage and support entry into and successful career progression through the health professions in general.

Action Steps

4.1) Institutional leaders should assess diversity and representation across their organizations, including among executives, administrators, faculty, staff, trainees, and students. They should examine which practices, processes, policies, etc., support success and retention and which present barriers and cause attrition—with the goal of building proficiency in advancing diversity, equity, and inclusion in health professions learning environments.

4.2) Leaders should continue to advocate at local, state, and national levels for policies and funding that support diverse health professions students and faculty, beginning with high-quality, STEM-focused education at prekindergarten and from kindergarten to 12th-grade (K-12) levels.

4.3) Leaders should codevelop, in partnership with K-12 schools and undergraduate institutions, programs and initiatives to provide students with early and continued exposure to all health professions. Learners who enter these programs should be followed longitudinally and programs should have standardized, measurable outcomes.

4.4) Leaders should ensure collection of a set of standardized diversity-related student and faculty data and be transparent in reporting the data (StrivePartnership at strivepartnership.org is a model for collecting data on students that is made available to everyone).

4.5) Regulatory and credentialing bodies should enforce reporting of data. Best practices for gathering and reporting diversity-related metrics should be developed and disseminated, and these metrics should be included in accreditation and national indexes. Recognition in performance reviews and promotions for meeting student and faculty diversity goals should become standard.

4.6) Health professions institutions should diversify representation on their admissions committees and adopt and enforce holistic admissions processes. Schools should impose term limits on admissions committee members and adopt quality control processes, such as standardized interviews, to detect and mitigate harmful bias in admissions interviews.

4.7) Institutional leaders, deans of admissions and student affairs, graduate training program directors, and members of admissions and recruitment committees, as appropriate, should be held accountable for achieving diversity-related goals in student recruitment, admissions, retention, and graduation. Inclusive and evidence-based assessments should be used for learner admissions and for progression.

4.8) Deans of admissions, deans of student affairs, and admissions committee members as well as human resources staff and those responsible for executive, administrator, and faculty recruitment should receive training in implicit bias and advancing diversity, equity, and inclusion in health professions learning environments.

4.9) Leaders of health professions institutions should develop and engage in evidence-based practices that support recruitment, mentoring, and retention of underrepresented faculty members.

4.10) Leaders should make it possible for more people from diverse backgrounds to choose careers in the health professions by ensuring that innovative, nontraditional pathways and collaborative educational models are developed and implemented at many educational levels (this can include early and meaningful exposure to all health professions, academic and personal support during undergraduate pre-health science classes, team education models, etc.). Such support should include access to robust and culturally aware mental health resources.

Conclusion

Macy President Humphrey concluded the meeting by thanking the conferees for their honest and courageous participation and for inspiring her. "I am dismayed that the topics discussed here at this conference have been challenging our nation for 500 years or more and are still with us, to the point that it sometimes feels like we're moving backward instead of forward," she said. "But you all and your willingness to engage in this discussion—as difficult as it was at times—have inspired me to keep moving forward. We must keep moving forward. We must keep striving for excellence in our health professions learning environments."

Immediately after the conference, Dr. Humphrey's call—echoing that of the conferees—to keep moving forward and striving for excellence by advancing diversity, equity, and inclusion in the health professions took on added urgency as the COVID-19 pandemic proceeded to change the world. As the pandemic raged through the spring of 2020, it became increasingly evident that historically marginalized populations were suffering and dying from COVID-19 at higher rates than White people. In reporting this information, *The New York Times* focused on bias as a reason for the disparity; for instance, one story was titled "Questions of Bias in Covid-19 Treatment Add to the Mourning for Black Families" (Eligon, Burch 2020). The story was subtitled, "The Centers for Disease Control and Prevention have advised health professionals to be on the lookout for medical bias." The imperative to address harmful bias and discrimination in health care is real—people are dying. The national movement in spring 2020 to address racism in our nation gives added impetus to this work.

Glossary

bias: preconceived notions based on beliefs, attitudes, and stereotypes about people belonging to certain social categories (source: Mateo, Williams 2020). Some bias is implicit, meaning that there's "a tendency for stereotype-confirming thoughts to pass spontaneously through [people's] minds. . . . It sets people up to overgeneralize" and possibly discriminate (source: scientificamerican.com/article/how-to-think-about-implicit-bias/).

disadvantaged/excluded/marginalized/vulnerable groups or populations: terms applied to people who, due to factors usually considered outside their control, do not have the same opportunities as more privileged groups in society. For example: "Structural inequalities between members of more advantaged and more disadvantaged population groups are a central feature of all societies. These inequalities are deeply rooted in the past and have been carried forward into the present. Their persistence severely undermines local, national, and global efforts to promote advances in the quality of life and well-being of people at all levels of social, political, and economic organization" (source: doi.org/10.1007/978-94-007-0753-5_742).

discrimination: inequitable treatment or impact of policies and practices on members of certain social groups that results in social advantages or disadvantages (source: Mateo, Williams 2020).

diversity: "embodies inclusiveness, mutual respect, and multiple perspectives and serves as a catalyst for change resulting in health equity" and it encompasses "all aspects of human differences such as socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, disability and age" (source: mededportal.org/diversity-inclusion-and-health-equity).

equity: in the context of health, equity is "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities" (source: healthypeople.gov/2020/about/foundation-health-measures/equity).

health disparities: "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion." (source: healthypeople.gov/2020/about/foundation-health-measures/Disparities).

health inequities: "differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work, and age. Health inequities are unfair and could be reduced by the right mix of government policies." (source: who.int/features/factfiles/health_inequities/en/).

health professions learning environments: "social interactions, organizational cultures and structures, and physical and virtual spaces that surround and shape participants' experiences, perceptions, and learning" (source: macyfoundation.org/assets/reports/publications/june2018_summary_webfile_7.20.18.pdf).

heterosexism/homophobia: heterosexism and homophobia are closely related but distinct concepts. "[H]omophobia generally refers to an individual's fear or dread of gay men or lesbians, [while] heterosexism denotes a wider system of beliefs, attitudes, and institutional structures that attach value to heterosexuality and disparage alternative sexual behavior and orientation" (sources: dictionary.apa.org/homophobia and dictionary.apa.org/heterosexism).

inclusion: is a core element for successfully achieving diversity. Inclusion is achieved by nurturing the climate and culture of the institution through professional development, education, policy, and practice. The objective is creating a climate that fosters belonging, respect, and value for all and encourages engagement and connection throughout the institution and community (source: aamc.org/professional-development/affinity-groups/gdi).

intersectionality: a term coined by legal scholar and civil rights activist Kimberlé Crenshaw in a 1989 *University*

of Chicago Legal Forum article focusing on the exclusion of Black women from antidiscrimination laws, anti-racism doctrine, and feminist theory. Today, the dictionary defines it as "the complex and cumulative way that the effects of different forms of discrimination . . . combine, overlap, and . . . intersect" (sources: chicagounbound.uchicago.edu/uclf/vol1989/iss1/8 and merriam-webster.com/words-at-play/intersectionality-meaning).

prejudice: "a negative attitude toward another person or group formed in advance of any experience with that person or group. Prejudices include an affective component (emotions that range from mild nervousness to hatred), a cognitive component (assumptions and beliefs about groups, including stereotypes), and a behavioral component (negative behaviors, including discrimination and violence). They tend to be resistant to change because they distort the prejudiced individual's perception of information pertaining to the group. Prejudice based on racial grouping is racism; prejudice based on sex is sexism; prejudice based on chronological age is ageism; and prejudice based on disability is ableism" (source: dictionary.apa.org/prejudice).

privilege: "the idea . . . that some people benefit from unearned, and largely unacknowledged, advantages, even when those advantages aren't discriminatory" (source: newyorker.com/books/page-turner/the-origins-of-privilege).

racism: "a form of prejudice that assumes that the members of racial categories have distinctive characteristics and that these differences result in some racial groups being inferior to others. Racism generally includes negative emotional reactions to members of the group, acceptance of negative stereotypes, and racial discrimination against individuals; in some cases it leads to violence" (source: dictionary.apa.org/racism).

social determinants of health: "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels." Some have recommended renaming them as "social and economic factors that affect health" to avoid suggesting that they are unchangeable and determine a person's life course (source: who.int/social_determinants/sdh_definition/en/).

social justice: "the view that everyone deserves equal rights and opportunities—this includes the right to good health" (source: apha.org/what-is-public-health/generation-public-health/our-work/social-justice).

Endnotes

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