WASHINGTON STATE MEDICAL ASSOCIATION
HOUSE OF DELEGATES

Resolution: B-8
(A-20)

Subject: Diversity and Inclusion in the Field of Medicine in Washington State

Introduced by: Rajneet Lamba, MD, Delegate
Daniel Low, MD, Delegate
Amish Dave, MD, MPH, Delegate
King County Medical Society

Referred to: Reference Committee B

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1 WHEREAS, the American Medical Association (AMA) recognizes that racism in its systemic,
2 structural, institutional, and interpersonal forms is an urgent threat to public health;[1] and
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4 WHEREAS, the AMA opposes all forms of racism; and
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6 WHEREAS, health equity, defined as optimal health for all, is a goal toward which our AMA
7 will work by advocating for health care access, research and data collection, promoting equity
8 in care, increasing health workforce diversity, influencing determinants of health, and voicing
9 and modeling commitment to health equity;[2] and
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11 WHEREAS, in 2019 the AMA created a health equity office and appointed its first chief health
12 equity officer;[3] and
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14 WHEREAS, our AMA has stated that it will take a leadership role in efforts to enhance diversity
15 in the physician workforce, including engaging in broad-based efforts that involve partners
16 within and beyond the medical profession and medical education community. This includes
17 actively working and advocating for funding to support the following: (a) Pipeline programs to
18 prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity
19 or minority affairs offices at medical schools; (c) Financial aid programs for students from
20 groups that are underrepresented in medicine; and (d) Financial support programs to recruit and
21 develop faculty members from underrepresented groups;[4] and
22
23 WHEREAS, our AMA advocates for the tracking and reporting to interested stakeholders of
24 demographic information pertaining to URM status collected from Electronic Residency
25 Application Service (ERAS) applications through the National Resident Matching Program
26 (NRMP);[4] and
27
28 WHEREAS, the AMA began issuing a yearly report on the demographics of its House of
29 Delegates to include information regarding age, gender, race/ethnicity, education, life stage,
30 present employment, and self-designated specialty. This report was issued in 2019 and future

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[1] https://www.ama-assn.org/press-center/ama-statements/ama-board-trustees-pledges-action-against-racism-police-brutality
[2] https://www.ama-assn.org/delivering-care/patient-support-advocacy/ama-puts-its-organizational-muster-behind-health-equity
[3] https://www.ama-assn.org/press-center/press-releases/ama-announces-first-chief-health-equity-officer
[4] https://policysearch.ama-assn.org/policyfinder/detail/faculty%20diversity?uri=%2FAMADoc%2Fdirectives.xml-0-505.xml

reports will identify and include information on successful initiatives and best practices to promote diversity;[5] and

WHEREAS, our country has a long history of systemic oppression against Black people. The AMA has a history of discrimination and disenfranchisement of Black physicians that has limited their access to careers in medicine as AMA membership was a requirement for hospital privileges and specialty training.[6] Black physicians remain underrepresented in the field of medicine, in the AMA and its House of Delegates, but recently have shown increased representation at the Board of Trustees level, making up 15% of its board; and

WHEREAS, our country has a long history of systemic oppression against Indigenous people. The AMA demographic data reveals Indigenous physicians remain underrepresented in both the field of medicine and within leadership in the House of Delegates and Board of Trustees; and

WHEREAS, the AMA demographic data reveals an underrepresentation of women physicians, Hispanic physicians, Asian/Asian American physicians, and International Medical Graduates (IMG) in its House of Delegates and Board of Trustees relative to their representation of total physicians and medical students in the US; and

WHEREAS, the racial and gender disparities described above are known to commonly exist in medical associations across the country; and

WHEREAS, the Washington Medical Commission reports data on physician demographics with regard to age, gender, race, IMG status, and practice type;[7] and

WHEREAS, the Washington State Medical Association tracks demographic data based on gender, age, practice locations and reports this out to membership; and

WHEREAS, the Washington State Medical Association has stated in its 2020 Strategic Plan that "recent events highlighting structural racism and health inequities have necessitated that we change our priorities and focus for the remainder of 2020 and beyond," and this plan involves hiring a consultant to help with membership structure and governance work;[8] THEREFORE BE IT

RESOLVED, that the Washington State Medical Association (WSMA) expand its review of demographic data in the organization to include information on race/ethnicity and International Medical Graduate status within the organization including its Board of Trustees, Executive Committee and staff, report this out to membership and take action to reduce any inequities that may be identified above and report these actions out to membership (New HOD Policy; Directive to Take Action); and BE IT FURTHER

RESOLVED, that the WSMA support efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve a wide array of partners both within and outside the medical profession. This includes advocating for funding to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial

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[5] https://www.ama-assn.org/system/files/2019-08/a19-clrpd-report-1.pdf
[6] https://journalofethics.ama-assn.org/article/american-medical-association-and-race/2014-06
[7] https://wmc.wa.gov/sites/default/files/public/MD%20Report%20July%202020.pdf
[8] https://wsma.org/WSMA/About/Who_We_Are/Who_We_Are.aspx

1 support programs to recruit and develop faculty members from underrepresented groups (New
2 HOD Policy); and BE IT FURTHER
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4 RESOLVED, that the WSMA encourage medical schools and residency programs in the state
5 of Washington to review and publicly report data on their diversity in terms of race/ethnicity.
6 (New HOD Policy)

Fiscal Note: None

HOUSE ACTION: ADOPTED ______ ADOPTED AS AMENDED ______

FILED______ REFERRED ______ NOT ADOPTED ______

WSMA Policy

Civil Rights and Responsibilities
The WSMA is in favor of equality of opportunity in medical society activities, medical education and training, employment, and all other aspects of medial professional endeavors regardless of race, color, religion, creed, ethnic affiliation, national origin, sexual orientation, gender identity, or sex. (Reaffirmed A-17) (Modified by Res 8-8, A-18)

The WSMA is unalterably opposed to the denial of membership privileges and responsibilities in county medical societies and state medical associations to any duly licensed physician because of race, color, religion, creed, ethnic affiliation, national origin, sexual orientation, gender identity, or sex. (Reaffirmed A-17) (Modified by Res B-8, A-18)

The WSMA calls upon the medical profession and all individual members of the WSMA to exert every effort to end any instances in which equal rights, privileges, or responsibilities are denied because of discrimination, including discrimination based on sexual orientation or gender identity. (JC 9.03-87) (Reaffirmed A-17) (Modified by Res B-8, A-18)

Principles on Physician Profiling
The WSMA has adopted the following principles on physician profiling and the public release of physician-specific data:

1. Physician organizations and practicing physicians who are representative of the profile group shall be meaningfully involved in the development of all aspects of the profile methodology, including collection methods, formatting, and methods, means and appropriate audience for release and dissemination.
2. The entire methodology for collecting and analyzing the data shall be disclosed to all relevant physician organizations and to all physicians under review.
3. Data collection and analytical methodologies shall be used that meet accepted standards of validity and reliability.
4. The limitations of the data sources and analytic methodologies used to develop physician profiles, as well as appropriate and inappropriate uses of the data, shall be clearly identified and acknowledged.
5. Physician profiling initiatives shall use standard-based norms derived from widely accepted, physician-developed practice guidelines to be used primarily to educate physicians.
6. Physician profiles and any other information regarding physician performance shall be shared with those physicians under review prior to dissemination. Opportunity for corrections or the addition of helpful explanatory comments shall be provided prior to publication. The profiles shall either include only data that reflect care under the control of physician for whom the profile is prepared or shall state to what extent the data are not under the control of the physician.
7. Comparisons of physician profiles shall adjust for patient case mix and other relevant risk factors, control for physician peer group when appropriate, and distinguish between the ordering or referring physician and the physician providing the service or procedure.
8. Effective safeguards to protect against the unauthorized use or disclosure of physician profiles shall be developed and implemented.
9. Effective safeguards to protect against the dissemination of inconsistent, incomplete, invalid, inaccurate, or subjective profile data shall be developed and implemented.
10. The quality and accuracy of physician profiles, data sources, and methodologies shall be evaluated regularly.
11. Physicians should be reimbursed for the reasonable costs that are required for assembling, formatting, and transmitting data and information to organizations that develop and/or disseminate physician profiles.

12. The benefits of physician profiling should outweigh the costs of developing and disseminating the profiles. (CPA Rpt D, A-95)
13. Physician-specific information released to the public must be relevant, meaningful, helpful, and reliable.
14. Information released to the public should be conclusive; that is, information should not be released until a final determination is made.
15. Information released to the public should be verifiable.

(CPA Rpt A, A-98) (Reaffirmed A-17)

Medical Students
Our WSMA supports leadership activities to train the next generation of physician leaders, including medical students, residents and fellows. (Res B-3 A-17)
Our WSMA supports funding for members of the WSMA Medical Student Section and members of the WSMA Resident and Fellow Section to attend the annual WSMA Leadership Development Conference. (Res B-3 A-17)

Discrimination in Physician Employment
The WSMA endorses non-discrimination in physician employment, compensation, and advancement opportunities consistent with the Washington State Equal Pay Opportunity Act by publishing expectations for employers of physicians. (Res B-12, A-18)
The WSMA endorses the concept that employers should demonstrate fair and equitable compensation among employees. (Res B-12, A-18)

Health Equity
The WSMA believes that a healthy Washington will require leadership and partnership of businesses, advocacy groups, community non-profits, environmental justice organizations, chambers of commerce, religious organizations, labor organizations, educational organizations, professional associations and others. (Res B-4, A-13)
The WSMA: 1) Supports the goal of addressing social determinants of health; 2) Supports the efforts of community initiated and driven action projects, private, non-profit and academic sectors independently and in collaboration with government to achieve health equity and eliminate racial/ethnic inequities in Washington; and, 3) Supports reaching out to diverse communities to assist them in addressing health inequities (Res B-4, A-13)

Promotion of Health Equity Through Graduate Medical Education in Critical Race Theory for Washington Physicians
The WSMA acknowledges that physicians and health care professionals wield power, privilege, and responsibility for dismantling structural racism in medicine and have an obligation and opportunity to contribute to health equity through legislative action and advocacy. (Res C-18, A-19)
The WSMA acknowledges that the disparate health outcomes of black Americans in the United States can be seen as an extension of a historical context where non-white, and specifically black, lives have been devalued. (Res C-18, A-19)
The WSMA support a professional education program for its members on critical race theory in medicine with special attention to four key areas: 1. learning, understanding, and accepting America's racist roots; 2. understanding how racism shapes the disparities narrative; 3. defining and naming racism; and 4. recognition of racism, and not just race. (Res C-18, A-19)