11.2.7 – Responsibilities to Promote Equitable Care

Medicine at its core is a moral activity rooted in the encounter between a patient who is ill and a physician who professes to heal. The "covenant of trust" established in that encounter binds physicians in a duty of fidelity to patients. As witness to how public policies ultimately affect the lives of sick persons, physicians' duty of fidelity also encompasses a responsibility to recognize and address how the policies and practices of the institutions within which physicians work shape patients' experience of health, illness, and care. As the physical and social settings of medical practice, hospitals and other health care institutions share the duty of fidelity and, with physicians, have a responsibility to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable.

Enduring health disparities across patient populations challenge these duties of fidelity. Disparities reflect the habits and practices of individual clinicians and the policies and decisions of individual health care institutions, as well as deeply embedded, historically rooted socioeconomic and political dynamics. Neither individual physicians nor health care institutions can entirely resolve the problems of discrimination and inequity that underlie health disparities, but they can and must accept responsibility to be agents for change.

In their individual practice, physicians have an ethical responsibility to address barriers to equitable care that arise in their interactions with patients and staff. They should:

(a) Cultivate self-awareness and strategies for change, for example, by taking advantage of training and other resources to recognize and address implicit bias;

(b) Recognize and avoid using language that stigmatizes or demeans patients in face-to-face interactions and entries in the medical record;

(c) Use the social history to capture information about non-medical factors that affect a patient's health status and access to care to inform their relationships with patients and the care they provide.

Within their institutions, as professionals with unique knowledge, skill, experience, and status, physicians should collaborate with colleagues to promote change. They should:

(d) Support one another in creating opportunities for critical reflection across the institution;

(e) Identify institutional policies and practices that perpetuate or create barriers to equitable care;

(f) Participate in designing and supporting well-considered strategies for change to ensure equitable care for all.

As institutions in and through which health care occurs, hospitals and other health care institutions share medicine's core values and commitment of fidelity, and with it ethical responsibility to promote equitable care for all. Moreover, as entities that occupy positions of power and privilege within their communities, health care institutions are uniquely positioned to be agents for change. They should:

(g) Support efforts within the institution to identify and change institutional policies and practices that may perpetuate or create barriers to equitable care;

(h) Engage stakeholders to understand the histories of the communities they serve and recognize local drivers of inequities in health and health care;

(i) Identify opportunities and adopt strategies to leverage their status within the community to minimize conditions of living that contribute to adverse health status.

AMA Principles of Medical Ethics: I,VII,IX

Background report(s):

CEJA Report 04-A-23 Responsibilities to Promote Equitable Care

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS[*]

CEJA Report 04-A-23

Subject:	Responsibilities to Promote Equitable Care
Presented by:	Peter A. Schwartz, MD, Chair
Referred to:	Reference Committee on Amendments to Constitution and Bylaws

The disproportionate impact of the COVID-19 pandemic on minoritized and marginalized communities harshly illuminated ongoing inequities in health care across the globe. In the U.S., the pandemic lent new energy to calls for change within and outside medicine and health care. Even as the American Medical Association (AMA) drew on the *Code of Medical Ethics* as a key resource during this public health crisis, the Council on Ethical and Judicial Affairs recognized that additional guidance is needed to explicitly address the ethical implications of social forces that drive how and to whom health care is provided. What role, that is, should physicians and health care institutions play as agents for change in the face of manifest inequity?

Looking critically at the *Code,* the council observed that existing guidance does indeed speak to matters of fairness or justice in health care. Principle IX of the *AMA Principles of Medical Ethics* enjoins physicians to “support access to care for all people.” Opinions variously enjoin physicians to promote access to care and address financial barriers to care; to avoid discriminating against or exploiting patients and research participants; to be prudent stewards of health care resources in the interests of all; to ensure that limited resources are allocated solely on the basis of medical criteria; even to ensure that organs and tissues for transplantation are treated as a national rather than a regional or local resource. (Appendix A.)

At the same time, the council recognized that, for the most part, guidance in the *Code* focuses narrowly on the conduct of individual physicians in their interactions with individual patients. By presenting guidance that addresses the manifestations of inequitable care, not the root causes, the *Code* tacitly presumes that inequity flows straightforward from the decisions and actions of individuals. Yet medicine has long understood that social factors play a critical role in health status and health disparities.

Such an individualist approach further fails to realize that the social drivers of health have deep and powerful histories. While important and necessary, it is not sufficient to remind physicians of their professional ethical obligations not to discriminate against patients based on explicit and continuously evolving “protected categories” of civil rights law. A professional responsibility to promote equitable care calls for situated, historically informed social and political knowledge of a sort that physicians are not specifically trained in, however, and on forms of discernment and self-reflection on which ethics guidance is generally silent.

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[*] Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

This report by the Council on Ethical and Judicial Affairs seeks to explore more thoughtfully the joint responsibilities that physicians as individual professionals and health care institutions as sites of service have to ensure that all patients in their practices and communities receive “safe, effective, patient centered, timely, efficient, and equitable care.”[Opinion 1.1.6]

FOUNDATIONAL ETHICS

At its core, the *Code* rests on an understanding of medicine as inherently a moral activity, rooted in the encounter between “someone who is ill, on the one hand, and someone who professes to heal, on the other,” in the words of physician and ethicist Edmund Pellegrino [1]. The “covenant of trust” established in such encounters binds physicians in a duty of fidelity to patients. The *Code* enjoins physicians, as medical professionals, to “dedicate themselves to providing competent medical care and respect for human dignity and rights.”[Principle I] Doing so encompasses a responsibility for physicians to “examine their own practices to ensure that inappropriate considerations about race, gender identity, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect their judgment.”[Opinion 8.5] Competent physicians “cultivate continuous self-awareness and self-observation,” and strive to “be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient’s best interest.”[Opinion 8.13]

Together these commitments entail physicians’ responsibility to become attentive to how their own perceptions, attitudes, and assumptions can color how they interact with different patients and to take steps to ensure that in delivering care their behavior as individuals neither privileges some patients nor disadvantages others.

It is also the case that “clinical medicine is the final pathway through which public policies ultimately come to affect the lives of sick persons” [2]. Although Pellegrino had in mind the specific example of managed care as the public policy in question, his observation holds more broadly. Physicians’ duty of fidelity also encompasses the responsibility to recognize and address the ways in which the policies and practices of health care institutions shape patients’ experience of health, illness, and care.

SHIFTING PERSPECTIVE: FROM “CULTURAL COMPETENCE” TO “STRUCTURAL COMPETENCE”

Training physicians for “cultural competence” has been promoted as a way to ensure that physicians take account of non-medical dimensions of health and illness, with the ultimate goal of promoting robust respect for patient autonomy and improving quality of care. By learning how to recognize “cross-cultural expressions of illness and health,” the thinking has been, physicians would “be able to counteract the marginalization of patients by race, ethnicity, social class, religion, sexual orientation or other markers of difference” [3]. Yet as the physician anthropologist Arthur Kleinman noted, “culture” is not reducible to a technical skill in which clinicians can develop expertise [4]. Moreover, “cultural factors are not always central to a case, and might actually hinder a more practical understanding of an episode [of illness].”

Patients’ health status, outcomes, and experiences of care are shaped significantly by social, economic, and political drivers unrelated to cultural understandings of illness and healing [3,5]. To make meaningful progress in achieving equitable care, physicians must recognize how “the pathologies of social systems impact the material realities of their patients’ lives” [3]. As the pathologist Rudolf Virchow noted more than a century ago, “If medicine is to fulfill her great task, then she must enter the political and social life. Do we not always find the diseases of the populace traceable to defects in society" [5]?

Truly to address their patients' health needs, physicians must acquire skills, not of cultural competence, but of "structural competence." That is:

> the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication "noncompliance," trauma, psychosis) also represent downstream implications of a number of upstream decisions, about matters such as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of health and illness [3,6].

ADDRESSING INEQUITY, PROMOTING EQUITABLE CARE[1]

Public health expert Camara Jones observed that when people think about "racism" they think of "personally mediated racism": the expression of prejudice and discrimination based on "differential assumptions about the abilities, motives, and intentions of others" and "differential actions toward others according to their race" [7]. Personally mediated racism may be intentional or unintentional, manifest in acts of commission and acts of omission. Jones distinguishes this from "institutional racism," that is, "differential access to goods, services, and opportunities of society by race." Institutionalized racism, she notes, is structural, "codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator."

Fulfilling the ethical responsibility to promote equitable care, then, requires that medicine address inequity and discrimination not only at the level of personal interactions among physicians and patients, but equally at the institutional level in the policies and practices that structure interactions within an institution's walls and in the institution's interactions with the community (communities) beyond its walls.

Personal Interactions

Physicians individually cannot be expected to repair structural discrimination and inequity in health care on their own, but they *can* hold themselves accountable for the ways in which their own interactions with patients, families, and fellow health care personnel may contribute to perpetuating discrimination and inequity. Doing so requires that physicians cultivate awareness of how they perceive others, how they speak about or describe persons and medical conditions, and how they approach interactions with patients and others one on one. As first steps, they must address in their own behaviors and implicit biases, such as the use of stigmatizing language and habits of discrediting patients' knowledge and reports of illness. So too, adopting a trauma-informed care approach can help physicians recognize and address the medical and psychosocial effects for patients of persistent marginalization and discrimination.

Implicit bias. In its 2003 report, *Unequal Treatment,* the Institute of Medicine linked health care professionals' implicit bias—that is, bias, prejudices, and stereotypes that are not consciously held or recognized—to health disparities [8]. Subsequent research has confirmed that in health care, bias is "negatively associated with both care satisfaction and provider trust among racial/ethnic minority patients" [9]. Among African American patients, for example, physicians' implicit bias has been

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[1] See Appendix B for selected resources for individuals and institutions.

shown to be a “relatively consistent predictor of ethnic/racial differences in patients’ subjective experiences with their health care providers” [10].

Whether implicit bias is straightforwardly linked to discriminatory behavior is open to question [10], but learning to recognize one’s own biases offers a point of entry for cultivating the awareness and critical self-reflection required of physicians as medical professionals. The most effective training will affirm learners’ egalitarian goals and commitment and go beyond raising awareness to teach how to control implicit bias, using active learning techniques that enable learners to practice new skills [10]. Training to “replace negative nonverbal or paraverbal behaviors with positive communication behaviors” can be a practical, attainable way to improve health outcomes [11].

Stigmatizing language. How physicians and other health care personnel speak to and about patients conveys multiple messages, intended and otherwise. Languages that “others” patients, “blames” them for their illness, or casts them as dangerous or threatening can influence care in the moment and risks perpetuating bias by inscribing it in the medical record [12,13]. Thus the U.S. National Institute on Drug Abuse, for example, offers preferred language for talking about addiction [14]; Diabetes Australia likewise draws attention to problematic language used about diabetes [15]. Phrasing that suggests negative attitudes toward patients, questions patients’ credibility, conveys disapproval of patients, or stereotypes them by race or social class captured in the medical record can undermine care [13]. By the same token, complimenting patients, offering patient-centered accounts of health behaviors that minimizes blame, and incorporating into the record details that personalize the patient as an individual can foster less discriminatory, more effective interactions [13].

Language that calls into question patients’ credibility or their ability to report their experience of illness accurately or appropriately constitutes a form of *epistemic injustice* [16]. It demeans patients as knowers based on physicians’ expectations, explicit or implicit, about what information is relevant and meaningful for the health care encounter. It privileges a biomedical model of disease over patients’ culturally and socially informed explanatory models and lived experience of illness [4], at times in ways that may actually be harmful to patients when marginalizing their reports of illness undermine diagnostic accuracy, isolate patients, or even lead them to withdraw from care [17]. Epistemic injustice may be both more common and more likely to be harmful for patients whose conditions are poorly understood or contested biomedically—as has been the case with chronic fatigue syndrome, for example [17]. By minimizing or outright dismissing the patient’s contribution to the encounter, physicians undermine trust and the opportunity to create an effective therapeutic relationship.

Trauma-informed practice. Adopting a trauma-informed approach to care offers further opportunity for physicians and other health care professionals to promote equitable care. Trauma-informed care recognizes that trauma “has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being” [18]. “Trauma” encompasses more than the effects of a specific event—sexual abuse, interpersonal violence, or exposure to combat, for example [19]. It also acknowledges the impact of social, economic, and political structures that cause harm to individuals and communities captured in Paul Farmer’s concept of “structural violence” [20], which can carry forward through descendants of those who suffered [E.g., 21,22].

Suggestions for implementing trauma-informed care focus on patient-centered communication practices, understanding the effects of trauma, interprofessional collaboration, understanding how one’s own experience of trauma may influence interactions with patients, and specific screening for trauma [19]. Trauma-informed practice acknowledges that physicians cannot change a patient's past; rather, it offers a way to help improve patients' function and well-being in the present [23].

Institutional Policies and Practices

Health care institutions share in medicine's fundamental commitment of fidelity to patients. Institutions are the physical and social settings of medical practice, constellations of resources and relationships established to enable the provision of care. Indeed, health care only happens in and through institutions. They reflect the attitudes of clinical professionals, administrators, and society even as they help to form the attitudes of practitioners and shape the delivery of care. In contemporary health care, institutions are the primary medium by which health care interacts with the political, economic, and social structures of society and the major means by which care is delivered. They too bear the ethical responsibilities of medicine.

The policies and practices of health care institutions importantly determine what care choices are available to patients and physicians. Regardless of size, physician practices, hospitals, and other institutions share responsibility to promote equitable access and care for all. What an institution chooses to know about its patients and staff and how that information factors into institutional decision making and patterns of practice can play a significant role in whether or to what extent the institution promotes equitable care across the board.

Social drivers of health. Just as how physicians perceive, speak about, and interact with others can perpetuate discriminatory attitudes and inequity, so too can organizational decisions about what information the institution captures about the patients it serves, how it does so, how that information is available to clinicians for treatment purposes, and how (or whether) it informs institutional operations. The foundational "explanatory model" of allopathic medicine—to borrow Kleinman's terminology again—grounds diagnosis and treatment jointly in biological function and personal health behaviors, despite ample evidence that social factors powerfully influence health and the delivery of health care [3,20,24].

Recognition of the significant health impact of structural factors has led to calls to rethink the social history to capture information beyond questions about tobacco or alcohol use to glean information about the socioeconomic and political realities of patients' lives.[25]. For example, initiatives at Brigham & Women's Health and Massachusetts General Hospital have expanded history taking to gather information about patients' particular life circumstances, emotional health, perceptions of health care, and health-related behaviors, as well as access to and utilization of health care [26]. Other institutions have deployed tools to assess patients' "structural vulnerability," including whether someone has money to pay for rent, food, and utilities; a safe, stable place to sleep; friends, family, or others who can provide help when needed; or has experienced discrimination [27,28].

Some health care institutions have gone beyond collecting data to intervene directly to address the extra-medical factors that so deeply affect health through initiatives to promote income security, medical-legal partnerships to help patients address legal issues that impinge on health status, and clinic-based child literacy programs among others [29,30].

Race-based versus race-conscious tools. As CEJA noted in its 2021 informational report on augmented intelligence in medicine, scholars have argued compellingly that medicine in the U.S. helps to perpetuate racial discrimination and inequity—and provide inadequate clinical care—when it grounds research and clinical practice in notions of race as unproblematically a genetic, biological characteristic of patients rather than a socially mediated classification of persons [31,32].

A growing body of evidence demonstrates that race-adjusted practices, intended to improve care, are often in fact harmful [32], particularly as a result of biases built into clinical algorithms and machine learning tools intended to support prediction of risk or diagnosis [33,34].

Nonetheless, ignoring race and ethnicity entirely can also be damaging. As imperfect as the category of race (/ethnicity) is, as a proxy measure it does indirectly capture important information about the influence of sociocultural, economic, environmental and genetic factors on health and health outcomes [31]. Scholars urge scientists and clinicians to continue to use categories of race and ethnicity until better predictors become available [31]. Ensuring that when racial categories are used, they promote equitable health remains of the upmost importance, however.

Aversive racism. How institutions interact with and treat their staff and affiliated personnel can also perpetuate discrimination and inequitable care—e.g., policies and practices for hiring and promoting personnel can reflect aversive racism, "which results from the interplay of … social dominance, implicit bias, and in-group favoritism" [35]. Aversive racism is reflected in laments about lack of qualified candidates from historically minoritized communities; it attributes an individual's inability to thrive within an organization to their personal characteristics or behaviors; and it buys into the "myth of meritocracy" that sees success as a function of ability while ignoring the effects that structural inequity has on opportunity. To the extent that racial, ethnic, or gender concordance between patient and physician improves patient satisfaction with care and health outcomes, fostering and respecting diversity among health care personnel can be a path toward promoting more equitable care.

Equity, safety, and quality improvement. As a species of "wicked problem," a term first introduced in the realm of urban planning [36], inequitable care doesn't lend itself to a simple, one-time solution. Wicked problems are dynamic, highly complex, and resistant to solution; generally there is "significant disagreement [among stakeholders] about the nature and cause of the problem and . . . potential solutions" [37]. By their nature, wicked problems cannot be solved by individual action but must be addressed at the organizational or systems level. To address ongoing inequities in care, institutions must first acknowledge that such inequities exist—they must ensure that they have compendious information about patients and leverage that information to understand where and how change needs to be made. For example, studies show that African American patients with heart failure tend to have poorer outcomes than white patients—but *why* that is the case isn't apparent without further exploration. A retrospective study at Brigham & Women's Health found that patients who receive care in a cardiology unit rather than on a medical ward have better outcomes, and that African American and Latinx patients were less frequently admitted to cardiology from the emergency department, as were women, suggesting an institutional pattern that may contribute to disparate outcomes [38].

Health care institutions in fact already have models on hand that can be adapted to promote equitable care in the form, especially, of patient safety initiatives [39]. Like patient safety, equity initiatives can focus on redesigning the processes and systems that perpetuate discrimination and inequity. In both realms, well-designed initiatives:

> balance [a] systems approach with individual accountability. Both recognize the role of cognitive, often subconscious biases in contributing to unintentional harm. Both highlight the importance of psychological safety to support difficult conversations. And both avoid excessive focus on individual or interpersonal blame. The goal isn't to shame individual clinicians but to build resilient systems around them that support optimal behaviors [39].

ADVOCATING FOR CHANGE

For both individual health care professionals and for health care institutions, the commitment to serve patients in need entails obligations to examine prevailing attitudes, habits, policies, and practices that determine what care is available to whom and to take steps to remove or re-engineer obstacles that undermine the ability to ensure equitable care for all.

Physicians have a responsibility to recognize that despite ongoing change in health care and seeming erosion of their authority they *do* have power within their institutions, and to use their voice and status to advocate for change. They have a responsibility to help create opportunities in which to raise challenging issues, to argue for tools to enable difficult conversations, and to develop relationships within their institutions to support one another. Ultimately, physicians have a responsibility to thoughtfully and constructively identify and begin to address the formal and informal expectations that create barriers to equitable care for their patients and equitable treatment of those who provide care and support caregiving within the health care institution.

Health care institutions have a responsibility to foster change within their walls, and to acknowledge the multiple roles they play in their communities. Health care institutions are deeply embedded in the life of their communities beyond their role in delivering care—they are employers, purchasers of goods and services, property owners, and civic leadership. A growing number of institutions recognize that as “anchor institutions” within their communities they can—and should—be agents for positive change. As member institutions of the Healthcare Anchor Network observe,

> Hospitals and health systems are critical local economic engines and mission-driven organizations inextricably linked to the long-term well-being of those we serve—because of this, we as healthcare leaders, are uniquely positioned and incentivized to play a more active role in supporting our local economies. We have an opportunity and obligation to improve health and well-being outcomes in the communities we serve and confront economic and social instability in our nation that remain obstacles to that goal [40].

The Institute for Healthcare Improvement’s Pursuing Equity Initiative identifies five strategies institutions should adopt to eliminate racism—and other forms of discrimination—in health care:

- Understanding the context of racism and other forms of oppression among the communities in which the institution is located;
- Normalizing discussion of oppression and listening to stakeholders to understand their experience;
- Meaningfully promoting workforce diversity;
- Developing and implementing business practices and policies through an equity lens;
- Adopting data systems that identify and track equity gaps in clinical outcomes;
- Using quality improvement strategies to narrow equity gaps and improve health care for all [41].

RECOMMENDATION

In light of these considerations, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

> Medicine at its core is a moral activity rooted in the encounter between a patient who is ill and a physician who professes to heal. The “covenant of trust” established in that encounter binds physicians in a duty of fidelity to patients. As witness to how public policies ultimately affect

the lives of sick persons, physicians' duty of fidelity also encompasses a responsibility to recognize and address how the policies and practices of the institutions within which physicians work shape patients' experience of health, illness, and care. As the physical and social settings of medical practice, hospitals and other health care institutions share the duty of fidelity and, with physicians, have a responsibility to ensure that the care patients receive is safe, effective, patient centered, timely, efficient, and equitable.

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In their individual practice, physicians have an ethical responsibility to address barriers to equitable care that arise in their interactions with patients and staff. They should:

a) Cultivate self-awareness and strategies for change, for example, by taking advantage of training and other resources to recognize and address implicit bias;
b) Recognize and avoid using language that stigmatizes or demeans patients in face-to-face interactions and entries in the medical record;
c) Use the social history to capture information about non-medical factors that affect a patient's health status and access to care to inform their relationships with patients and the care they provide.

Within their institutions, as professionals with unique knowledge, skill, experience, and status, physicians should collaborate with colleagues to promote change. They should:

d) Support one another in creating opportunities for critical reflection across the institution;
e) Identify institutional policies and practices that perpetuate or create barriers to equitable care;
f) Participate in designing and supporting well-considered strategies for change to ensure equitable care for all.

As institutions in and through which health care occurs, hospitals and other health care institutions share medicine's core values and commitment of fidelity, and with it ethical responsibility to promote equitable care for all. Moreover, as entities that occupy positions of power and privilege within their communities, health care institutions are uniquely positioned to be agents for change. They should:

g) Support efforts within the institution to identify and change institutional policies and practices that may perpetuate or create barriers to equitable care;
h) Engage stakeholders to understand the histories of the communities they serve and recognize local drivers of inequities in health and health care;
i) Identify opportunities and adopt strategies to leverage their status within the community to minimize conditions of living that contribute to adverse health status.

(New HOD policy)

Fiscal Note: Less than $500

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Appendix A
Existing Guidance on Justice

	Promote access/ address barriers to care	Do not discriminate	Do not exploit	Distribute benefits fairly	Distribute burdens fairly	Be prudent stewards of shared resources	Advocate for patients	Promote equitable care
Principle VII	X						X	
Principle IX	X							
1.1.2 Prospective patients		X				X		
1.1.6 Quality								X
1.1.7 Physician exercise of conscience		X						
1.1.8 Physician responsibilities for safe patient discharge		X				X	X	
6.2.1 Guidelines for organ transplantation from deceased donors	X	X				X		
6.2.2 Directed donation of organs for transplantation	X			X				
7.1.3 Study design and sampling		X			X			
7.3.2 Research on emergency medical interventions					X			
7.3.3 International research	X		X	X	X			
7.3.10 Expanded access to investigational therapies			x					
8.5 Disparities in health care	X	X		X				
8.11 Health promotion and disease prevention	X							
11.1.1 Defining basic health care	X		X		X		X	
11.1.2 Physician stewardship of health care resources	X						X	
11.1.3 Allocating limited health care resources			X		X	X		
11.1.4 Financial barriers to health care access	X							X
11.2.5 Retainer practices	X							
11.2.6 Mergers of secular and religiously affiliated health care institutions	X							X

APPENDIX B
SELECTED SAMPLE RESOURCES

Racial and Health Equity: Concrete STEPS for Smaller Practices
https://edhub.ama-assn.org/steps-forward/module/2782426?resultClick=1&bypassSolrId=J_2782426

National Institutes of Health – Implicit Bias Training Course
https://diversity.nih.gov/sociocultural-factors/implicit-bias-training-course

American Academy of Family Physicians – Implicit Bias Resources
https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit/implicit-bias.html

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National Institute on Drug Abuse – Words Matter
https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction

Temple Health – Reduce Stigmatizing Language in Healthcare
https://www.templehealth.org/for-physicians/reduce-stigmatizing-language

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Indiana University – Trauma-Informed Care Professional Development Certificate
https://rural.indiana.edu/impact/health/trauma-informed-care-certificate.html

Texas Department of Family and Protective Services – Trauma-Informed Care Training
https://www.dfps.texas.gov/Training/Trauma_Informed_Care/default.asp

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Centers for Medicare and Medicaid – Accountable Health Communities
Health-Related Social Needs Screening Tool
https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

American Academy of Family Physicians – Social Needs Screening Tool (Short Form)
https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf

Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE)
https://prapare.org/

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Racial and Health Equity: Concrete STEPS for Health Systems
https://edhub.ama-assn.org/steps-forward/module/2788862?resultClick=1&bypassSolrId=J_2788862

AMA – Advancing Equity Through Quality and Safety Peer Network
https://www.ama-assn.org/about/ama-center-health-equity/ama-advancing-equity-through-quality-and-safety-peer-network

Anchor Mission Playbook – prepared by Rush University
https://www.rush.edu/sites/default/files/2020-09/rush-anchor-mission-playbook-091117%282%29.pdf

Institute for Healthcare Improvement – Pursuing Equity Learning and Action Network
https://www.ihi.org/Engage/Initiatives/Pursuing-Equity/Pages/default.aspx