REPORT OF THE BOARD OF DIRECTORS

Subject: **Interim Report of the FSMB Workgroup on Diversity, Equity and Inclusion in Medical Regulation and Patient Care**

Referred to: **Reference Committee**

The FSMB Workgroup on Diversity, Equity, and Inclusion (DEI) in Medical Regulation was charged with identifying best practices for state medical boards to mitigate and eliminate systemic inequities in medical regulation and patient care. In completing its charge, the Workgroup will:

1. Collect and analyze data about membership on state medical boards to evaluate diversity in relation to licensee and patient populations;
2. Evaluate existing educational programs and initiatives for mitigating bias, addressing systemic inequities, and achieving cultural safety, directing efforts for the creation of new educational opportunities where need exists;
3. Identify best practices for ensuring fairness and incorporating the principles of equity and inclusion in board decision making related to licensing and disciplinary action; and
4. Promote a better understanding of the impacts of bias, inequity and systemic racism on medical regulation, health, and health care.

The Workgroup held virtual meetings in July and October 2021, during which members discussed historical elements of racism, bias and systemic inequity in medical regulation and patient care, and reviewed efforts to address these by state medical boards, regulatory authorities from international jurisdictions, and partner organizations.

During Workgroup meetings, members provided direction for research and resource development efforts, including:

- Drafting survey questions for the annual omnibus state medical board survey distributed to state medical board executive directors;
- Drafting a glossary of key terms; and
- Creating a visual representation of board processes to identify vulnerabilities, and into which existing and potential strategies for mitigating bias and avoiding discrimination can be included.

Following the workgroup's October meeting, additional one-on-one meetings were held to provide members with the opportunity to engage in informal discussion with the workgroup Chair to share what they felt should be included in an interim workgroup report, as well as ongoing priorities for a final report to be completed in 2023. There was substantial consensus across these meetings about the need to firmly situate DEI on the agendas of state medical boards, identify initial steps that could be easily implemented by boards, including education of board members, staff and licensees, and strategies for data collection and use.

Following these meetings, an interim report was drafted and shared with workgroup members on February 3, 2022. The draft interim report contains a glossary with more than 40 key terms that relate to DEI in medical regulation and patient care. It also presents Equity, Health Equity, Anti-Discrimination, Diversity, Inclusion, Cultural Humility, Justice, Transparency and Collaboration as foundational principles for the report. After presenting information to build a strong case for the relevance of DEI considerations to the work of state medical boards, the interim report provides background information on the FSMB's work in this area, as well as that of state medical boards. It then provides initial guidance regarding education for board members, staff and licensees; commentary on data collection, analysis and policies for data use; communication strategies; suggestions for increasing diversity in board member appointments; and considerations for the development of patient and practice resources.

The interim report was shared with state medical boards and partner organizations in February and March of 2022. Feedback received was incorporated into a revised draft which was considered by the Executive Committee of the FSMB Board of Directors in March 2022.

ITEM FOR BOARD ACTION:

The Board of Directors recommends that:

The House of Delegates ADOPT the recommendations contained in the Interim Report of the FSMB Workgroup on Diversity, Equity and Inclusion in Medical Regulation and Patient Care, and the remainder of the report be filed.

DIVERSITY, EQUITY AND INCLUSION IN MEDICAL REGULATION AND PATIENT CARE

Interim Report of the FSMB Workgroup on Diversity, Equity and Inclusion in Medical Regulation and Patient Care

Submitted to the FSMB House of Delegates, April 2022

INTRODUCTION

Systemic racism, discrimination and structural inequities cause many Americans to experience alarming levels of disparity in access to healthcare resources and in achieving quality health outcomes. Indigenous Americans and Alaska Natives have higher mortality rates in multiple categories, including diabetes, chronic liver disease and cirrhosis, influenza and pneumonia.[1] Life expectancy for individuals with physical, intellectual and developmental disabilities is less than for individuals without disabilities.[2] A Puerto Rican baby is twice as likely to have a low birth weight as a non-Hispanic white baby.[3] Hispanics are three times as likely as whites, and nearly twice as likely as blacks, to be uninsured.[4] Deaths attributable to COVID-19 in Black and Hispanic individuals far outpace those among white people, and disparities in receipt of medications for treatment of COVID-19 have been documented.[5] Racism is now being called a leading cause of death in the United States and systemic racism one of the most influential social determinants of health.[6] These and numerous other effects of racism on many populations and individuals have led the Centers for Disease Control and Prevention (CDC) to declare that racism is "a serious public health threat that directly affects the well-being of millions of Americans."[7]

Racism, bias and inequity also impact elements of medical licensing and discipline. A recent analysis requested by the Medical Board of California demonstrated that a correlation could be drawn between physician ethnicity and the pattern of complaints, investigations and discipline. "After controlling for a number of other variables, Latino/a and Black physicians were both more likely to receive complaints and more likely to see those complaints escalate to investigations.

[1]Disparities. Indian Health Service, U.S. Department of Health and Human Services (October 2019). https://www.ihs.gov/newsroom/factsheets/disparities/.

[2] Forman-Hoffman, V. L., Ault, K. L., Anderson, W. L., Weiner, J. M., Stevens, A., Campbell, V. A., & Armour, B. S. (2015). Disability status, mortality, and leading causes of death in the United States community population. *Medical care*, *53*(4), 346–354. https://doi.org/10.1097/MLR.0000000000000321

[3] Velasco-Mondragon E, Jimenez A, Palladino-Davis AG, Davis D, Escamilla-Cejudo JA. (2016) Hispanic Health In The USA: A Scoping Review of The Literature. *Public Health Rev*. 37:31. (Dec 7. 2016) doi:10.1186/s40985-016-0043-2.

[4] Jesse C. Baumgartner et al., *How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care* (Commonwealth Fund, Jan. 2020). https://doi.org/10.26099/kx4k-y932

[5] Wiltz JL, Feehan AK, Molinari NM, et al. (2022) Racial and Ethnic Disparities in Receipt of Medications for Treatment of COVID-19 — United States, March 2020–August 2021. *MMWR Morb Mortal Wkly Rep* 71: 96–102. http://dx.doi.org/10.15585/mmwr.mm7103e1

[6] Krumholz H M, Massey D S, Dorsey K B. (2013) Racism As A Leading Cause Of Death In The United States *BMJ* 376.

[7] Rochelle P. Walensky, *Director, Centers for Disease Control and Prevention,* Media Statement on Racism and Health, Centers for Disease Control and Prevention (April 8, 2021), https://www.cdc.gov/media/releases/2021/s0408-racism-health.html.

Latino/a physicians were also more likely to see those investigations result in disciplinary outcomes."[8] Other state medical boards that have reviewed their own policies, procedures and regulatory outcomes are also beginning to see evidence of discrimination and bias in multiple areas.

The Federation of State Medical Boards (FSMB) acknowledges its role in a system that has allowed racist, biased, and inequitable influences to hinder patient safety and, in many instances, cause harm. The FSMB is committed to supporting an equitable health system by identifying and eliminating discriminatory practices which have no place in medical regulation or health care.

This report recommends meaningful and achievable steps that state medical boards, the FSMB, and our partners in medical education, regulation and practice may wish to consider as action items to eliminate racism and bias from health care delivery. In so doing, these entities will take steps to achieve a more equitable regulatory and healthcare delivery system for everyone. Concepts covered and recommendations provided in this report address:

1. The Current Status of DEI among State Medical Boards;
2. The Composition of State Medical Boards and the Board Appointment Process;
3. Education for board members, staff and licensees;
4. Data Collection, Analysis and Policies for Data Use;
5. Communication; and
6. Patient and Practice Resources.

The Workgroup hopes this interim report will start and continue this important conversation among medical boards and their partners in healthcare delivery.

Section 1. Charge

Recognizing the influences of inequitable factors on our healthcare and medical regulatory systems, Kenneth Simons, MD, Chair of the Federation of State Medical Boards (FSMB), created the FSMB Workgroup on Diversity, Equity and Inclusion (DEI) in Medical Regulation and Patient Care (hereafter referred to as "Workgroup") in May of 2021, asking it to identify best practices for state medical and osteopathic boards (hereafter referred to as "state medical boards") to help recognize, mitigate and eliminate racism, discrimination and systemic inequities in medical regulation and patient care.

This Workgroup will continue and expand upon efforts initiated by FSMB Immediate Past Chair, Cheryl Walker-McGill, MD, MBA, who directed the FSMB to engage in an ongoing program of education to assist state medical boards in better understanding and addressing systemic racism, implicit bias and health inequity in medical regulation and patient care. Initial steps taken by the FSMB under Dr. Walker-McGill's tenure included a "Symposium on Health Equity" and an educational webinar on "Overcoming Implicit Bias in Health Care." Dr. Walker-McGill also created a Task Force on Health Equity and Medical Regulation, which provided guidance in the drafting of the FSMB's Statement on Diversity, Equity and Inclusion in Medical Regulation and

[8] Patrick Rogers. *Demographics of Disciplinary Action by the Medical Board of California (2003-2013)*. California Research Bureau (Jan. 2017).

Health Care, which was adopted and released by the FSMB's Board of Directors in April of 2021 (See **Appendix A**).

In continuance of this important work, Dr. Simons has asked the Workgroup to:

1. Collect and analyze data about membership on state medical boards to evaluate diversity in relation to licensee and patient populations;
2. Evaluate existing educational programs and initiatives for mitigating bias, addressing systemic inequities and achieving cultural safety, directing efforts for the creation of new educational opportunities where need exists;
3. Identify best practices for ensuring fairness and incorporating the principles of equity and inclusion in board decision making related to licensing and disciplinary action; and
4. Promote a better understanding of the impacts of bias, inequity and systemic racism on medical regulation, health and health care.

While the Workgroup will continue to meet in the coming year to further these goals, it offers the following report and recommendations in 2022 as interim findings and initial steps towards fulfilling its charge and in support of state medical board efforts to regulate the profession in a way that is equitable for licensees and ensures that patients receive non-discriminatory, unbiased care. It is anticipated that the final recommendations of the Workgroup will be submitted to the FSMB House of Delegates for its consideration in 2023.

Section 2. Glossary

Diversity, Equity and Inclusion ("DEI") are complex concepts with nuanced meaning and significant potential for misinterpretation. Clarity of meaning is, therefore, essential in discussions related to DEI and for the purposes of this report. As such, readers are strongly encouraged to familiarize themselves with the glossary of key terms that accompanies this report in **Appendix B**.

Section 3. Principles

Equity

Equity ensures fair opportunities for all by identifying and eliminating disadvantage based on preventable, avoidable and remediable circumstances. It is distinct from equality in that it requires equal consideration of all individuals based on their circumstances, but not necessarily equal treatment.[9]

[9] See also, Robert Wood Johnson Foundation, Equity vs. Equality (Video): https://www.youtube.com/watch?v=MlXZyNtaoDM

Health Equity

"Health Equity is the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographical areas in health status and health outcomes, such as disease, disability or mortality."[10]

Anti-Discrimination

Anti-discrimination signifies opposition to discrimination based on any of a variety of grounds, including race and ethnicity, sex, sexual orientation, gender identity, age, ability, socio-economic status and more. Legal protection from discrimination based on such grounds are included in the Civil Rights Act,[11] Americans with Disabilities Act,[12] and Affordable Care Act,[13] among others.

Diversity

Diversity is "the practice or quality of including or involving people from a range of different social and ethnic backgrounds and of different genders, sexual orientations, etc."[14] It is objectively defined and measured based on unique characteristics that individuals use to define who they are. It is expressed in myriad forms and embraces differences, while respecting a common humanity.

This document will often refer to specific examples of diversity, most of which are related to gender, race and ethnicity. This is meant to be illustrative only and not to exclude other forms of diversity, such as differences based on gender identity, sexual orientation, age, physical and mental ability, culture and many others. Diversity is also meant in this context to include diversity of perspective, incorporating differences in worldview.

Inclusion

Inclusion fosters belonging, engagement and connection by actively ensuring that differences are welcomed, and different perspectives are sought, heard and valued. Inclusion requires deliberate action to create a welcoming, respectful and safe environment for all.

Cultural Humility

Cultural humility is a framework for moving us toward equity that involves a lifelong process of self-reflection, self-critique and commitment to understanding and respecting different points of view, while engaging with others humbly, authentically and from a place of learning.[15]

[10] U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Health Equity. *Health Equity Report 2019-2020: Special Feature on Housing and Health Inequalities*. 2020. Rockville, Maryland.

[11] Civil Rights Act of 1964 § 7, 42 U.S.C. § 2000e et seq (1964)

[12] Americans With Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 328 (1990).

[13] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010)

[14] Oxford English Dictionary (n.d.), Retrieved February 16, 2022, from https://www.lexico.com/en/definition/diversity

[15] Tervalon M and Murray-García J (1998) Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education, *Journal of Health Care for the Poor and Underserved*, Vol.9, no.2.

Justice

Justice refers to fairness, impartiality and equal consideration in the way people are treated. With respect to the practice of medicine, fair and equitable treatment of all patients according to their needs is a professional expectation. In medical regulation, justice means fairness and impartiality in regulatory processes and in the fulfillment of the "patient protective" function of state medical boards. For justice to be achieved in both medical practice and medical regulation, efforts to mitigate and eliminate bias are required. Justice in healthcare and in medical regulation is fundamentally associated with opportunity.

Transparency

Transparency refers to the efforts of state medical boards to ensure that information about their processes is made available to the public and to the licensees to whom they apply. Transparency applies equally to the decisions and actions of state medical boards, as these and the rationales or justifications for regulatory decisions should be open to the public.

Collaboration

Successful delivery of equitable health care and implementation of fair medical regulatory processes require ongoing collaboration (or partnership) with communities served and professionals regulated. The experienced and expressed needs of individuals and communities should dictate how health equity can be achieved. This means listening to ascertain information about health needs or needs related to broader determinants of health, rather than attempting to impose solutions developed external to the communities or individuals they are meant to help. Similar outreach and listening are required within the medical regulatory community as well, to ensure that processes and decisions are informed by, and inclusive of, diverse perspectives and experiences.

Section 4. The Case for Diversity, Equity and Inclusion in Medical Regulation

Many studies identify significant inequitable outcomes among groups according to differences in race and ethnicity. Inequities based on characteristics of marginalized communities other than race and ethnicity are less studied but are beginning to garner more attention from researchers. Numerous types of disparities could be invoked in making an argument that outcomes are inequitable, but some of the most commonly cited and starkest of disparities involve infant mortality,[16,17] maternal pregnancy-related mortality[18,19] and heart disease.[20]

[16] Braveman P. (2008) Racial Disparities at Birth: The Puzzle Persists. *Issues in Science and Technology*. 24(2):23-20.

[17] Table 2, Infant Mortality Statistics from the 2018 Period Linked Birth/Infant Death Data Set. National Vital Statistics Reports Vol. 69 No. 7, https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR-69-7-508.pdf.

[18] Petersen EE, Davis NL, Goodman D, et al. (2019) Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. *MMWR Morb Mortal Wkly Rep* 68:762–765, http://dx.doi.org/10.15585/mmwr.mm6835a3external icon.

[19] *Pregnancy Mortality Surveillance System (PMSS), Centers for Disease Control and Prevention (2020),* https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm.

[20] Jemal A, Ward E, Anderson RN, Murray T, Thun MJ (2008) Widening Of Socioeconomic Inequalities In U.S. Death Rates, 1993-2001. *PLoS One*. May 14; 3(5): 2181.

We continue to uncover new examples of how health inequities negatively impact people and communities, especially those who have been historically marginalized. For example, a recent study was conducted of health care provider attitudes about disability and found that an overwhelming majority demonstrated implicit bias against people with disabilities.[21] While there are too many examples to include here, we highlight several to help provide some basic perspective and emphasis on why addressing DEI merits serious attention as a threat to public health:

- People of lower socioeconomic status are often perceived by lay people and medical providers as being less sensitive to pain and therefore in need of less intensive pain management.[22]
- Life expectancy for individuals with physical, intellectual and developmental disabilities is less than for individuals without disabilities.[23]
- Lesbian, Gay and Bisexual people have reported facing cases of providers denying care, using harsh language or blaming the patient's sexual orientation or gender identity as the cause for an illness.[24]
- Twenty-eight percent of respondents to the National Transgender Discrimination Survey in the U.S. reported postponing medical care due to discrimination, and the same percentage reported being harassed by providers when they sought care.[25]
- Indigenous Americans and Alaska Natives have higher mortality rates in multiple categories, including diabetes, chronic liver disease and cirrhosis, influenza and pneumonia.[26]
- A Puerto Rican baby is twice as likely to have a low birth weight as a non-Hispanic white baby.[27]
- Hispanics are three times as likely as whites, and nearly twice as likely as blacks, to be uninsured.[28]

[21] VanPuymbrouck, L., Friedman, C., & Feldner, H. (2020). Explicit and implicit disability attitudes of healthcare providers. *Rehabilitation Psychology*, *65*(2), 101–112. https://doi.org/10.1037/rep0000317

[22] Kevin M. Summers, Jason C. Deska, Steven M. Almaraz, Kurt Hugenberg, E. Paige Lloyd, (2021) Poverty and pain: Low-SES people are believed to be insensitive to pain, *Journal of Experimental Social Psychology*, Vol.95, 104116,
ISSN 0022-1031.

[23] Forman-Hoffman, V. L., Ault, K. L., Anderson, W. L., Weiner, J. M., Stevens, A., Campbell, V. A., & Armour, B. S. (2015). Disability status, mortality, and leading causes of death in the United States community population. *Medical care*, *53*(4), 346–354. https://doi.org/10.1097/MLR.0000000000000321

[24] When Health Care Isn't Caring: Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV (New York: Lambda Legal, 2010).

[25] Giffort, D. M., and Underman, K. (2016) The relationship between medical education and trans health disparities: a call to research, *Sociology Compass*, doi: 10.1111/soc4.12432

[26] Disparities. Indian Health Service, U.S. Department of Health and Human Services (October 2019). https://www.ihs.gov/newsroom/factsheets/disparities/.

[27] Velasco-Mondragon E, Jimenez A, Palladino-Davis AG, Davis D, Escamilla-Cejudo JA. (2016) Hispanic Health In The USA: A Scoping Review of The Literature. *Public Health Rev*. 37:31. (Dec 7. 2016) doi:10.1186/s40985-016-0043-2.

[28] Jesse C. Baumgartner et al., *How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care* (Commonwealth Fund, Jan. 2020). https://doi.org/10.26099/kx4k-y932

- Deaths attributable to COVID-19 in Black and Hispanic individuals far outpace those among white people, and disparities in receipt of medications for treatment of COVID-19 have been documented.[29]
- Racism is now being called a leading cause of death in the United States and systemic racism one of the most influential social determinants of health.[30]

These effects of racism on many populations and individuals have led the Centers for Disease Control and Prevention (CDC) to declare that racism is "a serious public health threat that directly affects the well-being of millions of Americans."[31]

It is undeniable that injustice and inequity exist in a variety of forms in our society, as they have in all societies throughout history. It is also apparent that inequities impact the health of the public, as evidenced by shocking disparities in health outcomes among communities.[32] These disparities in outcomes often do not disappear when controlling for factors such as income and insurance status,[33,34] so they cannot be fully explained by reference to features or behaviors of individual patients. This point is underscored by results of a recent survey of executives, clinical leaders, and clinicians at organizations worldwide, 48% of whom indicated that there are widespread disparities in the care delivered at their institutions.[35]

Given these and other disparities that are attributable not to individual or group characteristics or behavior, but to the ways in which these individuals and groups are impacted by the health and social systems of which they are a part, structural discrimination should be seen as a public health issue that merits not only the attention of those entities which control the health system, but also those in control of a variety of social structures as well. [36]

Discrimination and inequity in medical regulation have received less attention in the academic literature. However, while research about DEI in medical regulation is still relatively nascent, in recent years studies have helped identify some inequities and strategies to address them. For

[29] Wiltz JL, Feehan AK, Molinari NM, et al. (2022) Racial and Ethnic Disparities in Receipt of Medications for Treatment of COVID-19 — United States, March 2020–August 2021. *MMWR Morb. Mortal Wkly.* 71:96–102. DOI: http://dx.doi.org/10.15585/mmwr.mm7103e1.

[30] Krumholz H M, Massey D S, Dorsey K B. (2022) Racism As A Leading Cause of Death In The United States *BMJ*; 376 :o213 doi:10.1136/bmj.o213.

[31] Rochelle P. Walensky, *Director, Centers for Disease Control and Prevention,* Media Statement on Racism and Health, Centers for Disease Control and Prevention (April 8, 2021), https://www.cdc.gov/media/releases/2021/s0408-racism-health.html.

[32] Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. (2017) Structural Racism And Health Inequities In The USA: Evidence and Interventions. *Lancet*. 389(10077):1453-1463. doi:10.1016/S0140-6736(17)30569-X

[33] Institute of Medicine 2003. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press. https://doi.org/10.17226/12875.

[34] Williams, D. R., Priest, N., & Anderson, N. B. (2016). Understanding associations among race, socioeconomic status, and health: Patterns and prospects. *Health psychology : official journal of the Division of Health Psychology, American Psychological Association*, *35*(4), 407–411. https://doi.org/10.1037/hea0000242

[35] Health Inequity and Racism Affects Patients and Health Care Workers Alike. *NEJM Catalyst Insights Report*, March 2021.

[36] Rochelle P. Walensky, *Director, Centers for Disease Control and Prevention,* Media Statement on Racism and Health, Centers for Disease Control and Prevention (April 8, 2021), https://www.cdc.gov/media/releases/2021/s0408-racism-health.html.

example, the Medical Board of California recently requested that the California Research Bureau conduct an advanced analysis into potential bias in disciplinary processes. The analysis demonstrated that a correlation could be drawn between physician ethnicity and the pattern of complaints, investigations and discipline. "After controlling for a number of other variables, Latino/a and Black physicians were both more likely to receive complaints and more likely to see those complaints escalate to investigations. Latino/a physicians were also more likely to see those investigations result in disciplinary outcomes."[37] Another example comes from the Washington Medical Commission, where the board's Health Equity Advisory Committee has conducted a review of rules, policies, procedures and guidelines and identified several areas where improvement is possible to help mitigate and eliminate vulnerabilities to bias and discrimination.[38]

As more data are being collected about the demographic profiles of licensees, complainants, board members and staff, it is becoming possible to identify not only that there is a lack of diversity in medical regulatory processes, but also ways in which these processes are experienced by those affected, how they are vulnerable to such bias, and where discrimination may be occurring. Just as studying disparities in health outcomes helps us understand the systemic impacts of discrimination, a similar focus on disparities in regulatory outcomes may identify the ways in which structural discrimination has impacted medical regulation and begin to help chart a path towards rectifying them.

Section 5. State Medical Boards and DEI

Current Status of DEI among State Medical Boards

During the course of the FSMB's engagement with our member boards regarding DEI practices and policies, it has become apparent that boards are at very different places in their journeys in considering and addressing DEI on their own boards and in their licensee populations. Results from a recent FSMB survey indicate 45% (of 58 responding boards) assign a high priority level to diversity in the ways in which it regulates the profession of medicine, 56% for equity and 51% for inclusion. An additional 36%, 29% and 31% of responding boards assign a medium priority level to diversity, equity and inclusion, respectively, and many boards have discussed DEI with board members and staff. However, the ways in which these and other boards are carrying out processes related to DEI vary significantly. Some boards are taking important initial steps related to education and training on bias recognition and mitigation, while other boards have considered DEI a high priority for many years and have implemented data strategies for collection and bias mitigation, hired staff members with DEI-related portfolios, created task forces and committees to examine the DEI-related aspects of their work and have begun to make important changes to ensure more diversity on boards and in staff, foster inclusivity in discussions and achieve more equitable processes for licensees and the patient populations they serve.

[37] Patrick Rogers. *Demographics of Disciplinary Action by the Medical Board of California (2003-2013)*. California Research Bureau (Jan. 2017).

[38] Washington Medical Commission Health Equity Advisory Committee, https://wmc.wa.gov/policies-rules/health-equity-advisory-committee

Internationally, several jurisdictions are making efforts to make regulatory processes and health care delivery more equitable. New Zealand has been a leader in these efforts through its focus on the concept of cultural safety in the provision of care. This concept is explicitly linked to the promotion of health equity and it has resulted in a professional expectation that all doctors in New Zealand will meet cultural safety standards developed through a partnership involving the Medical Council of New Zealand and Te Ohu Rata o Aotearoa, the Māori Medical Practitioners Association and members of the medical profession.[39,40] In Australia, cultural safety is central to the Aboriginal and Torres Strait Islander Health Strategy, which was developed through a partnership between Aboriginal and Torres Strait Islander health organizations and national regulatory authorities, with support from academics, practicing clinicians and members of the public.[41] Recent efforts in Canada have centered around the concept of cultural humility as an essential component of professionalism in medicine. Canadian regulatory authorities have acknowledged that Indigenous-specific racism exists in medicine and medical regulation, and have deemed this and all forms of racism as professional misconduct.[42]

There are many moving parts involved in the work that state medical boards carry out to protect the public, from licensing through discipline. With each function carried out by a state medical board comes opportunities for bias to enter the board's work. Regardless of where a board finds itself on the spectrum of awareness and activities related to DEI, deciding on the next steps for addressing DEI at the board, staff or licensee level can be daunting.

To support state medical boards in their decision-making about how best to engage in DEI work, the Workgroup has engaged in the ongoing development of a "DEI Playbook" which is included at **Appendix C**. The DEI Playbook attempts to capture many of the processes involved in the work of state medical boards and suggests possible means of mitigating or eliminating bias through various policy, communications, legislative, and educational strategies and resources. Development of the Playbook will continue and a revised version will be presented to the FSMB House of Delegates as part of the Workgroup's Final Report in 2023. The Workgroup recommends that state medical boards consider the processes and potential strategies to determine whether the suggestions in the DEI Playbook could be implemented within their jurisdictions.

As any function of a state medical board is vulnerable to bias and discrimination, there is no right or wrong with respect to prioritization or strategy to start with, as long as the effort involves identifying vulnerabilities and working to address them. To provide additional guidance, the Workgroup suggests that consideration be given to broad categories in these areas: Board Composition and Appointments, Education, Data Collection and Use, Communication and Patient and Practice Resources.

[39] Medical Council of New Zealand, Cultural Safety: https://www.mcnz.org.nz/our-standards/current-standards/cultural-safety/.

[40] Curtis, E., Jones, R., Tipene-Leach, D. et al. (2019) Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *Int J Equity Health* 18, 174. https://doi.org/10.1186/s12939-019-1082-3

[41] Australian Health Practitioner Regulation Agency, The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025.

[42] Federation of Medical Regulatory Authorities of Canada, Statement on Indigenous-specific Racism in Recognition of the Inaugural National Day for Truth and Reconciliation, 30 September 2021.

Composition of State Medical Boards and the Board Appointment Process

There is strong evidence which demonstrates that a diverse medical profession, as well as greater diversity among those who make education and regulatory policy decisions, will lead to a more equitable system as a whole.[43,44,45] Similarly, a state medical board should be comprised of individuals who reflect the demography of the state's population. From a historical perspective, there is relatively little information available from the past about the diversity of members of state medical boards. Much of the available data is fragmented, anecdotal, imperfect and incomplete. However, it is evident from some of the data collected in the FSMB's archives that while there was little to no diversity on medical boards until the latter half of the twentieth century, significant progress has been made more recently, particularly in the last quarter-century.[46] Yet a great deal of progress has yet to be made given that neither the physician workforce, nor state medical board membership have near the degree of diversity of the general population.

Appointments to state medical boards are typically made by state governors or legislatures, sometimes with little to no input from the medical board itself. When efforts are not made to increase the diversity on boards by reaching out to historically marginalized communities or the organizations representing them and advocating on their behalf, the result is unsurprisingly a significant lack of diversity. A commitment to DEI requires *active* steps to increase diversity and this may be difficult given how non-diverse the medical profession, medical education, and most health systems are. "In the USA most hospital executives, clinical administrators, medical personnel, public health officials, insurance and pharmaceutical executives, medical educators and tenured faculty, NIH-funded researchers, directors of professional medical associations, and the student pipelines that precede each of these roles are white."[47] This sameness excludes participation from other historically marginalized groups and will persist unless we are intentional about increasing diversity.

However, many state medical boards do play a role in the nominations process by working with state and local organizations to draft lists of potential nominees. A helpful place to begin is with organizations representing physicians from groups that have been historically marginalized. Examples include state or local chapter affiliates of the National Medical Association (represents Black physicians), National Hispanic Medical Association, National Council of Asian Pacific Islander Physicians (represents Asian American, Native Hawaiian, and Pacific Islander physicians), Association of American Indian Physicians (representing Native American physicians), Society for Physicians with Disabilities, and the Gay and Lesbian Medical Association, among others.

Some state medical boards have also recognized the value that diversity can bring in support of their missions by adopting statutory requirements for a minimum level of board diversity based

[43] Eze N, Driving Health Equity Through Diversity in Health Care Leadership, *NEJM Catalyst*, October 20, 2020.
[44] Acosta DA, Poll-Hunter NI, Eliason J. (2017) Trends in racial and ethnic minority applicants and matriculants to U.S. medical schools, 1980-2016. *AAMC Analysis in Brief*. 17(3):1-4
[45] Rock D and Grant H, Why Diverse Teams are Smarter, *Harvard Business Review*, November 4, 2016.
[46] Data from FSMB archives collected and analyzed by David Johnson.
[47] Boyd, Rhea W. The Case for Desegregation, *Lancet*, Vol.393, no.10190, P2484-2485, June 22, 2019

on gender, race, ethnicity and other bases. For example, Iowa and North Dakota now have requirements for gender diversity on boards; Louisiana and Oregon require diversity based on ethnicity; and Alabama, Arkansas, Maryland, Missouri, North Carolina and Tennessee set minimum representation requirements based on both gender and ethnicity.[48] Maryland's particularly broad and helpful example is offered here as model statutory language:

"To the extent practicable, the members appointed to each health occupations board authorized to issue a license or certificate under this article shall reasonably reflect the geographic, racial, ethnic, cultural, and gender diversity of the State."[49]

Achieving diversity that is reflective of state or territorial population demographics is an important and meaningful, albeit incomplete, strategy. Diverse representation is meaningful in terms of the impacts it can have for mitigating bias, addressing and removing discrimination, and rectifying inequities if the diverse perspectives on a board are heard, respected and brought to bear on regulatory decisions of the board. This requires concerted efforts, however, on the part of board leadership and senior staff to create an environment and processes that lend themselves to fair and equal participation by all board members. In brief, to be impactful, diversity requires not only inclusivity but belonging.

Education

Many state medical boards have found education to be constructive and helpful as an initial strategy for addressing DEI. Several boards have organized educational sessions for board members and staff on topics such as anti-discrimination, health disparities and inequities, trauma-informed processes and bias recognition. Ensuring that board members and staff have similar understandings of what health inequities are, and how they relate to the "patient protective" function of the board, can support development of consensus about how this understanding should influence the board's work through process and policy changes.

Education of licensees is also critically important for achieving an appreciation among practicing physicians for the health impacts that systemic discrimination can have or unique care needs among vulnerable communities and individuals. It can also equip them with meaningful strategies for identifying and mitigating their own biases, communicating with patients, better understanding of the health issues facing their patients and adopting culturally safe and humble practices. Through the adoption of a resolution at its 2021 House of Delegates meeting, the FSMB has committed to encouraging the development and integration of medical education curricula specific to the care, treatment and management of patients with intellectual and developmental disabilities, as well as the inclusion of clinical competencies specific to this historically marginalized community.[50] Some state medical boards have also encouraged

[48] David Johnson, Andrea Anderson. How Diverse are State Medical Boards? *Journal of Medical Regulation* (2021) 107 (4): 33–36 (2021). https://doi.org/10.30770/2572-1852-107.4.33

[49] MD. Code Ann. Health Occ. § 1-214 (2010).

[50] Federation of State Medical Boards, Resolution 21-1: Incorporating the care of persons with intellectual and developmental disabilities into the medical school curriculum (Adopted 2021). Resolution introduced by The New York State Board for Medicine of the New York State Education Department's Office of Professions and the New York State Board of Regents.

licensees to engage in bias recognition and cultural humility education by creating resources[51] and highlighting opportunities on board websites[52] and in newsletters,[53] while others have specifically mandated that licensees engage in this education as a condition for license renewal.[54]

Data Collection, Analysis and Policies for Data Use

When used strategically, the data that state medical boards collect and use as part of their regulatory processes can have a significant impact on a board's ability to understand the diversity of its licensee population and ensure that it is operating in a way that results in equitable treatment of licensees and patients. According to results from the FSMB's Annual Survey, most state medical boards indicated that they collect data about licensee age, ethnicity and gender, but do not collect data beyond these categories. Only a third of responding boards collect data in these categories about boards members and far fewer about complainants. Boards also collect data about disability from licensees, however they are encouraged to review the guidance provided in the FSMB's Policy on Physician Wellness and Burnout[55] and its Policy on Physician Illness and Impairment[56] to ensure that data collection in these categories is consistent with best practices and compliant with the Americans with Disabilities Act.

State medical boards are encouraged to develop a strategy for collecting data from licensees, board members themselves, complainants and other members of the public with whom the board interacts. By disaggregating data (that is, creating subcategories of information collected), boards can better reveal inequalities and relationships between categories,[57] thereby better equipping them to identify areas where inequities exist. In instances where boards feel they are inadequately resourced to analyze and interpret large data sets, they are encouraged to develop partnerships with academic institutions in their state or territory or contact the FSMB for support.

Boards are encouraged to consider when it would be most effective and appropriate to request data from licensees, complainants or other parties to ensure that the collection process neither dissuades an individual from providing data, nor unduly burdens them. For example, it may be more appropriate to request certain types of demographic data that do not relate directly to the licensing process from licensees in survey form at the license renewal stage, rather than when they apply for initial licensure. This way they will not be wary of potential discrimination that may affect their ability to obtain licensure. The stakes are likely to be perceived as much lower at the renewal stage.

[51] See, e.g., State Medical Board of Ohio, *Cultural and Linguistic Competency Guide for Providers*, https://med.ohio.gov/Resources/Cultural-Competency
[52] See, e.g., Maryland Board of Physicians: https://www.mbp.state.md.us/forms/MHHD_%20implicit_bias.pdf
[53] See, e.g., Washington Medical Commission, https://wmc.wa.gov/sites/default/files/public/Newsletter/3.EDReport.pdf
[54] See, e.g., New Jersey Board of Medical Examiners: N.J.A.C. 13:35-6.25 and Oregon Medical Board: OAR 847-008-0077.
[55] Federation of State Medical Boards, Policy on Physician Wellness and Burnout, Adopted 2018.
[56] Federation of State Medical Boards, Policy on Physician Illness and Impairment: Towards a Model that Optimizes Patient Safety and Physician Health, Adopted 2021.
[57] British Columbia's Office of the Human Rights Commissioner, *Disaggregated Demographic Data Collection in British Columbia: The grandmother perspective*, September 2020.

Some state medical boards have also taken steps to selectively remove or redact data from documents that board staff or members review as part of licensure and disciplinary processes to mitigate against potential biases. Examples of potentially biasing information that could be redacted include gender, age, years in practice, race, ethnicity and medical school attended by the (prospective) licensee. Similar redaction could occur at the complaint level to ensure that complaints are being triaged equitably, based on the nature of the complaint and not the characteristics of the complainant.

Communication

A public statement from the state medical board which clearly expresses the board's position against discrimination in health care and in its regulatory processes may be a valuable strategy for several reasons. Achieving consensus about what such a statement should include can help begin an important conversation among board members. Clarifying the position of the board for licensees and the public can also be a transparent means of opening dialogue about various forms of injustice and DEI priority areas. An action-oriented and precise statement about steps the board is taking, or plans to take, can also create a new mechanism of accountability for the board, creates benchmarks against which to measure progress and demonstrate evidence of its commitment to the populations it serves. A public statement can also function as a bridge for reaching out to communities that have been historically marginalized to create opportunities to hear their concerns and involve them in the work of the board. At a minimum, boards should clearly express the professional expectation that care will be provided in an equitable and non-discriminatory manner.

State medical boards are increasingly demonstrating their commitment to DEI (and against discrimination) in a variety of innovative ways. Examples include narrative statements from board presidents,[58,59] executive directors[60] and senior staff;[61] special editions of board newsletters;[62] and statements of philosophy on cultural competency[63] or board position against systemic racism.[64] While there are many commonalities among these statements, key features are summed up clearly and in an action-oriented manner by the Washington Medical Commission in its statement, titled *Racism in All Its Forms is a Public Health Issue*, which lays out key steps for its own work to address systemic racism:

- "Accept that there is a problem.

[58] See, e.g., California Medical Board. Statement from President Pines: Wellness is Racial Justice, June 18, 2020, https://www.mbc.ca.gov/News/2020-06-18-President-Pines-Statement.aspx

[59] See, e.g., North Carolina Medical Board: https://www.ncmedboard.org/resources-information/professional-resources/publications/forum-newsletter/article/from-the-president-a-personal-perspective-on-race-equity-and-moving-forward-positively-in-difficult-times

[60] See, e.g., North Carolina Medical Board: https://www.ncmedboard.org/resources-information/professional-resources/publications/forum-newsletter/article/in-message-to-staff-ncmb-ceo-reaffirms-commitment-to-core-values

[61] See, e.g., Massachusetts Board of Registration in Medicine: https://www.mass.gov/doc/winter-2021/download?_ga=2.163612408.634649354.1625639905-2095302851.1625639905

[62] See, e.g., Medical Board of California: https://www.mbc.ca.gov/Download/Newsletters/Newslettter2020Summer.pdf

[63] See, e.g., Oregon Medical Board: https://www.oregon.gov/omb/Newsletter/Summer%202021.pdf.

[64] Washington Medical Commission, https://wmc.wa.gov/sites/default/files/public/Newsletter/RacisminAllItsForms.pdf.

- Acknowledge our role in continuing the systems that produce these outcomes.
- Use our position and privilege to change the systems to serve all people.
- As with medical error, we should recognize and apologize when our efforts to effect positive change do not have the desired impacts."[65]

Patient and Practice Resources

As noted, inequities in health status, access to services and outcomes have long existed in American society. In 2003 the Institute of Medicine (now the National Academy of Medicine) published a seminal report, titled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,*[66] which shed a spotlight on disparities and suggested that the many factors contributing to them may be grouped according to factors at the patient level (although these are reported as the least likely to be a major source of disparity), the level of the clinical encounter, and the healthcare system level, including the legal and regulatory environment in which a given system operates. While most of the identified factors at all three levels still exist and contribute to disparities, we now have nearly two decades of smaller scale initiatives that have aimed to address them. Many of these focus on the level of the clinical encounter and have made differences in the manner in which care is delivered. However, systemic inequities require systemic changes, and initiatives implemented at the level of the provider and patient will not have the intended success at reducing inequities that systemic initiatives and change can have.

Interventions at the clinical level are nonetheless important, especially for the purposes of protecting patients. Resources for patients that provide accommodations for disabilities, increase health literacy and provide information about how to communicate with state medical boards to enquire or complain about care that they feel may be discriminatory can help combat inequities in the clinical encounter. This can include tips or fact sheets that help patients understand whether they have been discriminated against by a licensee and, if so, what recourse they have. Such materials should include specific information in multiple languages and formats regarding how to access medical boards and what to expect from the process.

Many systemic factors leading to health inequities pertain to socioeconomic conditions that are typically considered outside the realm of health care. However, the medical education community is beginning to recognize that if the mission of health care involves improving the health of patients on a more than episodic basis, then attention to the broader determinants of health is necessary. Several curricular changes and new programmatic initiatives are taking place which do just that through partnerships with communities aimed at educating medical students who are able to look beyond a patient's presenting condition to consider their broader circumstances, provide information to patients based on their socioeconomic context and better listen to and communicate with patients, even advocating on their behalf when appropriate.[67,68]

[65] *Id*. https://wmc.wa.gov/sites/default/files/public/Newsletter/RacisminAllItsForms.pdf
[66] Institute of Medicine. 2003. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press.https://doi.org/10.17226/12875.
[67] Lewis JH, Lage OG, Grant BK, et al. Addressing the Social Determinants of Health in Undergraduate Medical Education Curricula: A Survey Report. *Adv Med Educ Pract*. 2020;11:369-377. Published 2020 May 22. doi:10.2147/AMEP.S243827
[68] See, e.g., A.T. Still University, School of Osteopathic Medicine in Arizona, "Students Embedded in Community Health Centers to Impact Health Disparities through Contextual Learning"

The FSMB commends medical schools for implementing such initiatives and encourages their wider adoption.

Section 6. Recommendations

The following recommendations are offered for consideration by state medical boards as part of the Workgroup's Interim Report. Additional recommendations will be made in the Workgroup's Final Report in 2023.

1. The FSMB formally adopt the FSMB Task Force's Statement on Diversity, Equity and Inclusion in Medical Regulation and Health Care, April 15, 2021 (**Appendix A**) as official FSMB policy.

2. State medical boards are encouraged to provide education and training to staff, board members, and licensees regarding cultural safety, humility, systemic racism and bias.

3. State medical boards should provide information and education to patients about what constitutes discriminatory or otherwise inequitable care, and how they can work with their state medical board to address it.

4. State medical boards are encouraged to consider the ways in which data is collected from licensees, complainants, and board members and staff in order to build the capacity to better understand diversity within these groups and identify disparities that may exist.[69]

5. State medical boards should consider ways of increasing their data-gathering and analytic capacity, through partnerships with government, academic institutions and the FSMB.

6. In order to help mitigate biases among staff and board members, state medical boards should consider redacting potentially biasing categories of data in licensing processes, and about complainants and respondents during complaint review, investigative, disciplinary and enforcement processes, including gender, race, ethnicity, age, medical schools attended, years in practice and others.

7. State medical boards should seek to increase the diversity of their board members and staff to mirror the population they serve through: (1) outreach to underrepresented communities and (2) statutory language that sets minimum standards for diversity through the appointments process.

CONCLUSION

Health and other forms of disparities have existed in American society for centuries while discrimination, from a broader perspective, has existed even longer. Discrimination is present in medical education and practice, as well as in medical regulation. If the medical regulatory community is to avoid being complicit in sustaining systemic racism, discrimination and bias,

[69] The Workgroup will recommend categories for a Minimal DEI Dataset in its Final Report to the FSMB House of Delegates in 2023.

and their impacts on the populations served by state medical boards, we must act now to put an end to these injustices. The Workgroup hopes that this report offers helpful steps that can be taken by state medical boards to achieve a more just healthcare and medical regulatory system.

APPENDIX A

FSMB Statement on Diversity, Equity and Inclusion in Medical Regulation and Health Care

(April 15, 2021)

Systemic racism and structural inequities are embedded in the American health care system and have given rise to a public health crisis. This is evidenced by alarming disparities in access to health care providers and resources, treatment and outcomes. The Federation of State Medical Boards (FSMB) is committed to supporting an equitable health care system.

These unjust aspects of our healthcare system have existed for centuries but receive periodic attention when the most grievous of inequities are brought to light by instances of inhumane treatment, severely disproportionate outcomes, racially motivated crimes, or public health emergencies. As long as structural and systemic inequities exist in society, they threaten medicine, health care and medical regulation. Yet, realizing a just health care system requires more than periodic attention. Sustained action across society is needed to address and rectify structural inequities and systemic racism. Acknowledging and understanding inequities in access to quality health care in America and working to achieve health equity through diversity and meaningful inclusion are fundamental to caring for the public we serve. Greater diversity in the health care workforce, as studies in the medical literature indicate, improves patient experiences and outcomes.

The FSMB's mission involves supporting state medical boards in their efforts to ensure safety for all patients. We acknowledge our role in a system that has allowed racist, biased, and inequitable influences to hinder that safety and harm patients, and we commit to identifying, addressing, and dismantling those influences. Fundamental to this role is the maintenance and strengthening of public trust in the practice of medicine and in professional self-regulation. For the FSMB and its member boards, ensuring diversity, equity and inclusion means maintaining a dual focus on our own policies and procedures to promote equity and eliminate systemic inequities, as well as ensuring that the care provided by licensed physicians, physician assistants and other health care professionals is equitable and not influenced by bias based on race, ethnicity or other forms of discrimination.

We support education about cultural safety throughout all stages of medical training and practice. We also support organizational change to ensure diversity, inclusivity and fair representation on state medical boards and in board staff that is reflective of the licensee and patient populations. This will require concerted effort to better engage with communities, especially ones that have been historically underrepresented, marginalized, intentionally mistreated and harmed, and unjustly treated, to promote their inclusion in medical regulation through a deeper understanding of the role of state medical boards.

In the past year, the FSMB has taken initial steps to address these issues by prioritizing discussion of health equity at meetings of our board governance. We hosted an educational webinar for our member boards addressing bias and, in January of 2021, a Symposium on Health Equity and Medical Regulation that included an array of experts in medical practice,

government, academia, and advocacy. We will leverage the expertise of our partners in the international community and continue to value and learn from the experiences they generously share.

We recognize that effectively addressing systemic racism and inequity requires ongoing action on multiple fronts. This is why we appointed the Task Force on Health Equity and Medical Regulation, to provide guidance and direction as we develop and sustain a lasting commitment to diversity, equity and inclusion.

The FSMB views diversity in all its forms as a strength and asset in combatting the unjust and racist elements in our healthcare system.

APPENDIX B

DEI Glossary

The Workgroup presents the following glossary to support a common interpretation of key terms related to diversity, equity and inclusion. The definitions herein are informed by or quoted directly from multiple different sources, as indicated in the citations.

Ableism
Individual, cultural, and institutional beliefs or practices that rest on the assumption that being able-bodied is "normal" while other states of being need to be "fixed" or altered. This can result in devaluing or discriminating against people with physical, intellectual or psychiatric disabilities. Institutionalized ableism may include or take the form of un/intentional organizational barriers that result in disparate treatment of people with disabilities.[70]

Affirmative Action
A systematic approach that gives preferential treatment to a marginalized group to eliminate, remedy, and prevent unlawful discrimination among applicants on the basis of race, creed, color, and national origin, among others. Affirmative action aims to achieve fair employment or representation and is not simply a quota system.[71]

Ageism
The individual, cultural, and institutional beliefs and discrimination that systematically oppress young and elderly people.[72]

Anti-Discrimination
Anti-discrimination is an elaboration of the concept of antiracism, advanced by Ibram X. Kendi,[73] that focuses on the outcomes of policies and procedures and which can function in the form of a test to determine which policies and procedures are in need of change and which are most worthy of creating or developing. Those policies and procedures which result in unequal or otherwise inequitable outcomes are considered, by definition, discriminatory; those which result in a reduction in inequality or inequity may be considered anti-discriminatory and should be implemented.

[70] Harvard University, Glossary of Diversity, Inclusion and Belonging (DIB) Terms, https://edib.harvard.edu/files/dib/files/dib_glossary.pdf
[71] Cornell Law School, Legal Information Institute, https://www.law.cornell.edu/wex/affirmative_action
[72] National Conference for Community and Justice, https://www.nccj.org/intersectionality
[73] Kendi, Ibram X. How to Be an Antiracist, 2019.

Anti-Racism

"Anti-racism is a strategy to achieve racial justice."[74] It requires conscious decisions to make frequent, consistent, equitable choices which aim to identify and confront racism by changing the systems that create and perpetuate it.[75]

Belonging

"Belonging is the feeling of security and support when there is a sense of acceptance, inclusion, and identity for a member of a certain group."[76] It involves being treated and feeling like a full member of a community where one can be their authentic self and thrive.[77]

Bias (Implicit, Unconscious)

A prejudice, attitude or stereotype in favor of or against something. When a bias is implicit or unconscious, it is operating without the knowledge, intention or awareness of an individual to influence (bias) their views or decisions.

BIPOC

BIPOC stands for Black, Indigenous, and People of Color. It is intended to be inclusive of traditionally marginalized or minoritized groups based on skin color, demonstrate solidarity among these groups, and highlight their unique relationship to whiteness and struggles against white supremacy.[78]

Classism

The institutional, cultural, and individual set of practices and beliefs that assign differential value to people according to their socioeconomic class in a social system characterized by economic inequality.[79]

Colorism

A practice of discrimination based on preference for lighter skin tone.

Cultural Competence

A framework for achieving culturally sensitive practice through an understanding of another's culture and experiences. This framework is often critiqued for suggesting that one can become

[74] American Medical Association and Association of American Medical Colleges. (2021) Advancing Health Equity: Guide on Language, Narrative and Concepts. Available at ama-assn.org/equity-guide.

[75] Harvard University Office for Equity, Diversity, Inclusion and Belonging, "Equity, Diversity, Access, Inclusion and Belonging, Foundational Concepts and affirming Language," October 6, 2021. https://edib.harvard.edu/files/dib/files/oedib_foundational_concepts_and_affirming_language_12.7.21.pdf?m=1638887160

[76] Cornell University Diversity and Inclusion, "Belonging," https://diversity.cornell.edu/belonging/sense-belonging

[77] Boden, S, A Primer on Diversity and Inclusion (Part 1 of 2), Harvard Business Publishing Corporate Learning (July 23, 2020) https://www.harvardbusiness.org/start-here-a-primer-on-diversity-and-inclusion-part-1-of-2/

[78] The BIPOC Project, https://www.thebipocproject.org/about-us

[79] Harvard University Office for Equity, Diversity, Inclusion and Belonging, "Equity, Diversity, Access, Inclusion and Belonging, Foundational Concepts and affirming Language," October 6, 2021. https://edib.harvard.edu/files/dib/files/oedib_foundational_concepts_and_affirming_language_12.7.21.pdf?m=1638887160

expert in another's culture, thereby suggesting an endpoint, rather than an ongoing commitment to a process of understanding and self-critique.

Cultural Humility

"Cultural humility incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations."[80]

Cultural Safety

A framework focused on self-examination and self-discovery in reflecting on one's beliefs, biases and attitudes.

Cultural Sensitivity

Cultural sensitivity means being aware of cultural differences and the ways these influence values, beliefs and behaviors.

Disability

The Americans with Disabilities Act defines disability as a physical or mental impairment that substantially limits one or more major life activities. The ADA also defines a person who has a history or record of such an impairment as disabled, as well as a person who is perceived by others as having such an impairment.[81]

Diversity

"The practice or quality of including or involving people from a range of different social and ethnic backgrounds and of different genders, sexual orientations, etc."[82]

Equality

"The state of being equal, especially in status, rights, and opportunities."[83]

Equity

Equity ensures fair opportunities for all by identifying and eliminating disadvantage based on preventable, avoidable and remediable circumstances. It is distinct from equality in that it requires equal consideration of all individuals based on their circumstances, but not necessarily through equal treatment.

[80] Tervalon M and Murray-García J (1998) Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education, *Journal of Health Care for the Poor and Underserved*, Vol.9, no.2.

[81] Americans With Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 328 (1990).

[82] Oxford English Dictionary (n.d.), Retrieved February 16, 2022, from https://www.lexico.com/en/definition/diversity

[83] Oxford English Dictionary (n.d.), Retrieved February 16, 2022, from https://www.lexico.com/en/definition/equality

Health Equity
"Health Equity is the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographical areas in health status and health outcomes, such as disease, disability or mortality."[84]

Ethnocentrism
Ethnocentrism denotes a cultural or ethnic bias that favors one's own group's ways and judges those of others as being inferior.

Favoritism
The practice of giving preference (or "favor") to individuals or members of a group over others.

Gaslighting
An abusive behavior used to trick, control or manipulate a person into questioning their own reality, memory or perceptions of events.

Heterosexism (or Heteronormativity)
The belief that heterosexuality is the only normal or acceptable sexuality and that all other sexualities are inferior.

Homophobia
"An aversion to lesbian or gay people that often manifests itself in the form of prejudice and bias. Homophobia is also a structural form of discrimination manifesting in policies and institutions. Similarly, biphobia is an aversion people who are bisexual, and transphobia is an aversion to people who are transgender. Collectively, these attitudes are referred to as anti-LGBTQ+ bias."[85]

Intersectionality
Intersectionality refers to interconnected, overlapping, and interdependent social categorizations such as race, class, and gender as they apply to a given individual or group, implying compounded discrimination or disadvantage. Intersectionality rejects the idea of unidirectional discrimination or discrimination on a single basis only.[86]

Justice
Justice refers to fairness, impartiality, and equal consideration in the way people are treated.

[84] U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Health Equity. *Health Equity Report 2019-2020: Special Feature on Housing and Health Inequalities*. 2020. Rockville, Maryland.

[85] Harvard University Office for Equity, Diversity, Inclusion and Belonging, "Equity, Diversity, Access, Inclusion and Belonging, Foundational Concepts and affirming Language," October 6, 2021. https://edib.harvard.edu/files/dib/files/oedib_foundational_concepts_and_affirming_language_12.7.21.pdf?m=1638887160

[86] Crenshaw K, "Demarginalizing the intersection of Race and Sex: A black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics,' University of Chicago Legal Forum: Vol.1989: Iss.1, Article 8.

Health Justice

Health Justice builds on the concept of health equity and notions of equal opportunity and requires addressing the broader social determinants of health through affirmative material and institutional support, as well as consideration of these determinants in policy, law, and social structures.

Marginalization

Marginalization is both a condition and a process that peripheralizes individuals and groups based on their identities, associations, experiences, and environment, thereby preventing them from full participation in social, economic, and political life enjoyed by the wider society.[87,88]

Microaggression

A microaggression is a brief and commonplace verbal or nonverbal exchange that cues a sense of subordination based on socially defined categories.

Oppression

Oppression occurs when a dominant group knowingly or unknowingly deprives another group of opportunities or freedom through the imposition of institutional power.

Prejudice

A prejudice is an unfair, unreasonable, unjustified, or incorrect attitude towards an individual, group, or idea. Prejudices are learned and can be unlearned. They are usually negative, but even when positive can lead to unfair or inaccurate preconceived notions about individuals or groups.

Privilege

Privilege denotes an unearned benefit, social advantage, or degree of prestige enjoyed by people of a particular group, solely by virtue of belonging to that group, but not available to others. In American society, privileged social identities typically include whites, males, heterosexuals, Christians, and the wealthy, among others.[89]

Race

"Race is a socially constructed way of grouping people, based on skin color and other apparent physical differences. It has been defined by an arbitrarily organized combination of physical traits, geographic ancestry, language, religion and a variety of other cultural features."[90] Race and ethnicity are often used interchangeably but do not share the same meaning.

[87] Alakhunova N, Diallo O, del Campo IM, Tallarico W, *Defining Marginalization, An Assessment Tool*, George Washington University, The Elliott School of International Affairs, May, 2015, https://elliott.gwu.edu/sites/g/files/zaxdzs2141/f/World%20Fair%20Trade%20Organization.pdf.

[88] Baah, F. O., Teitelman, A. M., & Riegel, B. (2019). Marginalization: Conceptualizing patient vulnerabilities in the framework of social determinants of health-An integrative review. *Nursing inquiry*, *26*(1), e12268. https://doi.org/10.1111/nin.12268

[89] The Libraries at Rider University, "Privilege," https://guides.rider.edu/privilege

[90] American Medical Association Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, 2021-2023.

Racism
As defined by Camara Jones, "racism is a system of structuring opportunity and assigning value based on phenotype ("race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources" Racism can operate at different levels: structural, institutional, interpersonal and internalized.[91,92]

Religionism
Discrimination based on religion.

Sexism
Discrimination based on sex.

Social Determinants of Health
"The underlying community-wide social, economic and physical conditions in which people are born, grow, live, work and age. They affect a wide range of health, functioning, and quality-of-life outcomes and risks. These determinants and their unequal distribution according to social position, result in differences in health status between population groups that are avoidable and unfair."[93]

Political Determinants of Health
Political forces (factors, systems, structures, including law and policy) that impact the health of individuals and the larger society.[94]

Structural Determinants of Health Equity
"Political-economic systems, whereby health inequities result from the promotion of the political and economic interests of those with power and privilege (within and across countries) against the rest, and whose wealth and better health is gained at the expense of those whom they subject to adverse living and working conditions."[95]

Stereotype
Assignment of assumed fixed, overgeneralized and oversimplified characteristics or attributes to the members of a given group (e.g., by ethnicity, nationality, class, or other status/identities)[96] which infers that an individual possesses the range of assumed characteristics of the group.

[91] Jones CP. (2003) Confronting institutionalized racism. *Phylon*. 50(1-2):7-22.
[92] American Medical Association and Association of American Medical Colleges. (2021) Advancing Health Equity: Guide on Language, Narrative and Concepts. Available at ama-assn.org/equity-guide.
[93] American Medical Association and Association of American Medical Colleges. (2021) Advancing Health Equity: Guide on Language, Narrative and Concepts. Available at ama-assn.org/equity-guide.
[94] Dawes D, The Political Determinants of Health, Johns Hopkins University Press, 2020.
[95] Krieger N. Epidemiology and the People's Health. Oxford: Oxford University Press; 2011.
[96] American Medical Association and Association of American Medical Colleges. (2021) Advancing Health Equity: Guide on Language, Narrative and Concepts. Available at ama-assn.org/equity-guide.

Tokenism

Tokenism is the practice of making only a perfunctory or symbolic effort to give the appearance of fairness, especially by recruiting a small number of people from underrepresented groups to give the appearance of sexual or racial equality within a workforce.[97]

[97] Oxford English Dictionary (n.d.), Retrieved February 16, 2022, https://www.lexico.com/en/definition/tokenism

APPENDIX C

Playbook: Regulatory Processes and Proposed Mitigation Strategies and Resources

The following tables highlight state medical board practices which may be vulnerable to bias and discrimination. Recognizing that not all state medical boards have the same degree of resources or operational autonomy to be able to implement DEI programs and strategies, the tables offer a variety of suggestions for how these vulnerabilities may be addressed. This "Playbook" will be further developed by the Workgroup, in collaboration with state medical board representatives, prior to presentation at the FSMB House of Delegates in April 2023.

Licensing	
Vulnerabilities	**Mitigation Strategies & Resources**
Exam Requirements	• Evaluate access barriers to exams, including cost, policies on retakes, ECFMG certification. • Consider possible subsidies through partnerships with funding organizations • Ensure that appropriate accommodations are available to examinees with disabilities.
Testing on Applications	• Consider bias training and education about Social Determinants of Health and health disparities. • Opportunity to reinforce bias mitigation as a professional responsibility.
Application Questionnaire	• Collect demographic data to achieve minimum DEI dataset and establish a baseline for measuring diversity. • Collection of data should not preclude redaction of potentially biasing data in licensing, disciplinary, or other processes.
Education/CME Requirements	• Consider recommendation or mandate of continuing medical education on bias and equity/disparities on initial licensing and license renewal. • FSMB to support boards through curriculum development and listing resources.
Access to educational, Exam Prep, Mentoring Resources	• Adopt position that socioeconomic status should not disadvantage access to exam prep courses. • Consider/Develop partnerships with professional organizations to subsidize or provide review materials.

USMG vs IMG Requirements	• Apply equity lens in consideration of rules/statutes that apply to IMGs vs USMGs. • Consider resources to help better differentiate quality of medical education beyond US vs "other".
Bias or Lack of Uniformity in Licensure Review Process	• Review licensing criteria to ensure consistency and standardization to avoid bias or "gut feelings" about candidates. • Establish process for review by multiple individuals when applications are identified as concerning. Ensure diversity among reviewers. • Apply equity lens in all application reviews.
Subjectivity in Reference Forms	• Consider subjectivity and potential bias in reference forms that accompany licensing applications.
Additional (Statutory) Requirements (e.g., explanation of leave from training/practice)	• Acknowledge changing norms regarding leave from practice for parental leave or other reasons that do not impact patient care. • Review processes and requirements for disclosure that may dissuade licensees from taking legitimate leave from practice, seeking treatment for health conditions, or are otherwise unfair.

Policy, Communications & Patient/Public Relations	
Vulnerabilities	**Mitigation Strategies & Resources**
Website	• Adopt a public statement explaining the board's position on diversity, equity and inclusion. This can outline the value of health equity for patients, the board's commitment to equitable processes for licensees, and the board's position against discrimination of any sort as a professional expectation. • Provide access to educational resources focused on reducing health inequities, mitigating bias or other opportunities to promote equity (e.g., FSMB educational resources). • Feature vignettes or narrative stories regarding health equity. • Highlight instances of systemic discrimination and advocate for change.
Policies and Guidelines	• Create committee responsible for reviewing all policies and guidelines through equity lens. • Enact regulations that bar discrimination by licensees.

	• Draft internal and external policies regarding non-discrimination and Anti-Racism. • Offer training to Board members and staff.
Publications (Newsletters, Journals, etc.)	• Ensure that all publications are accessible to persons with disabilities. • Dedicate space in board publications to DEI and consider "special editions." • Feature "stories" or vignettes from individuals reflecting experiences with diversity in medical regulation, education or patient care.
Social Media	• Leverage social media to promote awareness of systemic discrimination and opportunities for increasing DEI among licensees and the public. • Promote board efforts in DEI and celebrate achievements.
Advocacy (Selection of Issues)	• Seek input from board members, licensees and the public on issues they would like to see prioritized.
Involvement of Other Stakeholders (e.g., medical society, PHP)	• Conduct a landscape review to identify partners at the local, state and national levels that have a nexus to DEI and can support the board's DEI efforts.

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Complaints through Investigations	
Vulnerabilities	**Mitigation Strategies & Resources**
Information on Complaints Process and How to File	• Offer multiple pathways for filing complaints to make the complaints process more accessible to the public. • Consider whether language barriers exist to the complaints process. • Consider whether disability status presents a barrier to the complaints process. • Identify or hire a patient liaison or navigator to support complainants through the process.
Intake	• Collect, but redact information about the complainant that may be potentially biasing, e.g., age, gender, ethnicity, level of education completed, geographic location. • Collect, but redact information about the subject licensee, e.g., age, gender, ethnicity, medical school, specialty, type of practice.

	• Create complaints categories for allegations of bias, discrimination, and inequitable care.
Triage	• Include multiple individuals in the triage process for complaints that are not initially triaged to investigations. • Review "flagged" complaints through an equity lens, screen for bias against the complainant and the licensee.
Communication throughout Process	• Consider appointing a liaison, a staff member with a role to communicate with the complainant, provide updates as needed and be available to hear and respond to complainant questions/concerns.
Investigative Procedures	• Require all investigators and investigative team members to undergo bias training and trauma-informed training. • Track complaints which could be driven by discrimination. • Recognize the "upstream factors" that may disproportionately place licensees under board scrutiny.
Interaction with Complainant, Licensee, Other	• Provide opportunity for complainants to speak before the board, similar to licensee opportunity. • Offer patient liaison and interpretive services as needed. • Allow virtual and in-person options to increase accessibility.
Case Development (Legal Staff)	•

836
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Hearings and Discipline	
Vulnerabilities	**Mitigation Strategies & Resources**
Hearing Process	• Consider allowing complainants to testify before the board.
Adjudication	•
Publication of Disciplinary Actions	• Consider ways in which publication of particular details may stigmatize certain groups or individuals. • In cases involving discrimination or bias, use the opportunity to communicate that bias and discrimination

	constitute professional misconduct and are appropriately subject to regulation.
Monitoring	• Track and categorize all cases as "closed," "closed after investigation," "action taken" (including type of action and whether hearing occurred). • Facilitate retrospective analysis by including subcategories for each type of case, e.g., sexual misconduct, boundary violation, improper prescribing, substandard care, etc.
Remediation	• Collaborate with organizations that provide assessment and remediation services to ensure the availability of remedial education and training for physicians who engage in discrimination or who have exhibited biases.

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Board Functioning and Appointments	
Vulnerabilities	**Mitigation Strategies & Resources**
Board Member Appointments	• Adopt as policy that board composition should reflect the communities served. • Work with state government to develop approaches to increasing diversity among board members. • Partner with state and local organizations representing communities that have been marginalized to identify potential appointees.
Board Member Qualifications	• Evaluate requirement for board members to be American Citizens or graduates of US medical schools. • Consider removing age or minimum years in practice for board members to increase representation among newly practicing physicians.
Board Member Training	• Mandate bias training and trauma informed education.
Board Leadership	• Encourage diversity of board members who serve in leadership roles. • Consider whether compensation models are appropriate for service required.
Committee Creation and Member Selection	• Mandate minimum levels of diversity for membership on board committees.

Board Meeting Procedures	• Encourage opportunities for public and stakeholder comment at open meetings.

842

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