The Anti-Racist Family Physician: A Guide to Making a Difference

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Foreword

Racism impacts the practice of medicine in numerous ways, and the medical field has just begun to scratch the surface of solutions. Creating solutions is imperative in family medicine because social determinants of health, or SDOH, and biases within the exam room directly impact patients' health outcomes. This guide is designed to support family physicians on their journey to practice anti-racism within medicine by doing the following:

- Provide a framework of evidence-based, theoretically informed practices that family physicians can use to further develop an anti-racist practice
- Address prevalent misconceptions regarding race and promote the unlearning of harmful ideologies that historically have been propagated through medical education
- Equip family physicians to think critically about race-based medical practices
- Advance the establishment of a more equitable health care system
- Promote awareness of racism in the medical field
- Inspire family physicians to conduct intervention-based research that promotes and advances anti-racist practices

Rigorous methods were used to conduct a large-scale literature review. However, health equity is a broad topic area, and we recognize that this guide is not exhaustive. Numerous other interventions to promote health equity can and should be considered. Additional learning objectives will be identified by those who seek to address unanswered questions and research gaps. We hope this guide will encourage family physicians to advance intervention-based research focused on anti-racist practices and support them along their journey of learning and improvement.

This guide aims to counter the perpetuation of health disparities and social categorization in medicine. While we focus on the impact of racism, the practices discussed can also be useful in countering oppression that people within your practice may be facing on the basis of other identities (e.g., class, sex, gender, sexual orientation, differing ability, religion, nationality).

Please note: This guide may be used within groups or systems to help facilitate constructive group discussions on race and racism. It is common for uncomfortable emotions such as guilt, shame, disbelief and anger to arise when discussing racism. We recommend setting aside time to reflect upon these emotions. Information on how to process uncomfortable emotions is available in "Anti-Racism Tools for Change" (aafp.org/cme/all/health-equity/anti-racism.html), an on-demand continuing medical education activity that can be purchased from the American Academy of Family Physicians.

Cultivating Shared Definitions

The language used to describe facets of identity related to race and racism has been polarized and politicized. Thus, it is important to have shared definitions for key terms used within this guide (see *Appendix A*).

Racism and the Anti-Racist Physician

Benefits of Anti-Racist Practice:

- Promotes equity and inclusion
- Fosters a sense of belonging among all individuals regardless of race
- Creates opportunities for diverse perspectives and experiences to thrive
- Encourages empathy and understanding across racial lines
- Leads to systemic changes that address and dismantle racial inequalities

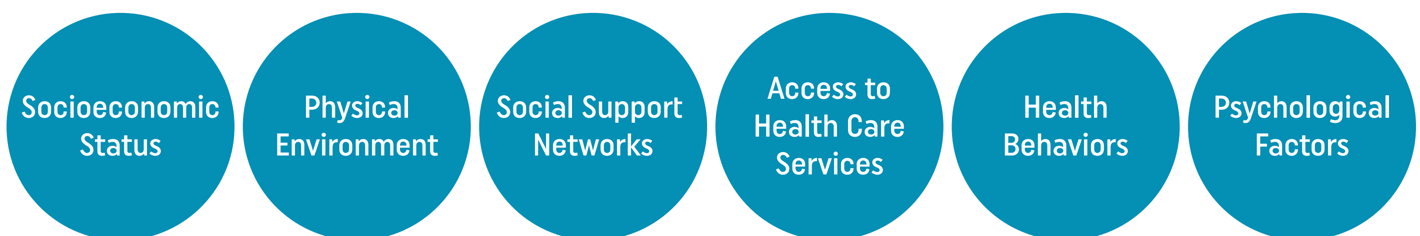
Harmful Effects of Racist Practice:

- Perpetuates discrimination and prejudice, leading to unfair treatment of individuals based on race
- Creates division and tension among different racial groups, undermining social cohesion
- Restricts opportunities and access to resources for historically marginalized racial communities
- Contributes to the perpetuation of stereotypes and biases, reinforcing harmful narratives about certain racial groups
- Stifles innovation and progress by excluding diverse perspectives and talents from contributing to society

Racism — which has now been named a public health issue — has negatively impacted the practice of medicine for centuries. Thus, it is no surprise that practicing anti-racism and being an anti-racist physician are parts of a journey rather than destinations. Anti-racism is more than just opposing racism. It involves continuously countering racism and the impact of racism within society. This can be difficult for clinicians to do unless they have knowledge and understanding of how racism impacts everyday medical practice.

The AAFP's policy on race-based medicine states, "Race is a social construct that is used to group people based on physical characteristics, behavioral patterns, and geographic location. Racial categories are broad, poorly defined, vary by country and change over time. People who are assigned to the same racial category do not necessarily share the same genetic ancestry; therefore, there are no underlying genetic or biological factors that unite people within the same racial category."[1] In spite of this, researchers have found that a patient's race can impact their health outcomes for reasons including social factors that impact patient care, biases that have become ingrained within medical training and practice, and assumed racial differences that affect treatment decisions.[2,3] As we navigate the ways racism impacts health disparities, the practice of medicine, diversity within the medical workforce and medical research, we encourage you to reflect upon your present knowledge and areas of future exploration in your journey to becoming an anti-racist physician.

Racism and Health Disparities



Racism is not limited to interpersonal exchanges. Structural and systemic racism affect all areas of life and contribute to the vast impact that racism has on health. Social determinants of health have been directly associated with the development of health inequities.[2-5] Policies rooted in racial division (e.g., redlining) have created present-day disparities in educational funding, food and health care accessibility, and environmental justice, all of which directly impact health status, equity and opportunity.

Initially, it may be easy for people to think that the condition of a neighborhood is the responsibility of those who live there. However, it is important to understand that opportunities and amenities like high-paying jobs, high-quality private education and healthful food options follow economic development. When decades of policies prevent economic development and investment in an area, those who live there have much less opportunity to improve their quality of life or take advantage of enriched experiences. This lack of development and investment not only negatively impacts tax revenue and future lending to the area but also leads to disinvestment by society at large. These areas are then labeled as "disenfranchised" or "vulnerable," and the health and other needs of residents are negatively impacted.

Sources note that health equity cannot be achieved without specifically targeting the racism and policy inequities that have created the current SDOH.[4,5] For family physicians, this complicates their duty to provide equitable care to all patients because SDOH create serious barriers to health for many people and contribute to up to 80% of variation in health outcomes for patients.[6] If family physicians are not prepared for the challenges posed by SDOH, they will not be able to achieve health equity for their patients. Other health care professionals, such as social workers and community health workers, can assist by providing some resources. However, in the aftermath of the COVID-19 pandemic, limited resources are available and burnout among health care professionals has resulted in a shrinking workforce.

Racism and the Practice of Medicine

Patients are not protected from racism in the exam room. Explicit and implicit biases within the health care team and social categorization in medicine impact both patients' access to care and their health outcomes. Explicit interpersonal racism against patients does take place in clinical encounters despite being socially unacceptable. More commonly, patients are impacted by biased policies and direct implicit associations from health care professionals.

Implicit biases can be both personal in nature and ingrained within the culture of medicine. For example, a physician may not even realize that they are not offering recommended screenings to an Asian patient. At first glance, this may seem like a mistake. However, if the physician's behavior occurs with all patients who appear Asian, it may be tied to implicit associations with stereotypes about people who identify as Asian, such as that they have superior health, follow non-Western medical practices or have less interest in Western medical interventions. These stereotypes are false and inherently cause harm, especially when one is making generalizations about such a large, diverse population of people. They are seen as a reason that patients who identify as Asian receive less routine screening than any other patient demographic,[7] which contributes to a disproportionately high number of cancer deaths within this population. For family physicians, increasing their awareness of implicit biases and changing their practices are crucial to ensuring equitable treatment of patients.

Social categorization in medicine results when stereotypes about or biases against certain patient populations are perpetuated in medicine alongside medical knowledge.[4] Researchers describe the hidden curriculum in medical education as "positive and negative lessons, which are embedded in organizational structure and culture…conveyed in medical schools, residency programs, hospitals, and clinics."[8] Negative lessons learned from the hidden curriculum in medical education (e.g., those regarding how to treat patients, what factors suggest malingering or alternative motives and how to decide what the right course for each patient is) not only impact patient outcomes but also allow falsehoods to become practice standards and create barriers to overcoming health disparities.[2,4]

The ills of racism have permeated the science and practice of medicine. For example, in the medical literature of the 1800s, Dr. Charles White was credited with stating that Black people who were enslaved experienced pain differently than white people.[9] This false belief became so ingrained in medical practice that evidence from recent studies still shows related biases among medical trainees and their impact on patient outcomes. For example, in 2012, studies showed inequities in pain control within the practice of primary care, including a higher likelihood of worse pain management, lower quality of life and greater disability from chronic pain among African American patients.[10] A 2016 study found that approximately 40% of first- and second-year medical students had false beliefs associated with Black people feeling pain less than white people.[11] These biases have also affected rates of amputation and the use of cardiovascular interventions and other treatments, with patients of diverse identities receiving lower-quality, more disfiguring options that yield debilitating results.[7]

Racism and Representation in the Medical Workforce

Lack of diversity within the medical workforce has been noted as a driver of health inequities.[12] Since physicians of diverse backgrounds may be more likely to question the validity of false beliefs and biases, lack of diversity also leads to the continuation of social categorization in medicine. The Flexner Report is one of many factors that have contributed to the lack of diversity in health care and the perpetuation of racism within medicine. Published in 1910, it was an evaluation of all the medical schools in the United States and Canada using metrics that prioritized opportunities for scientific advancement over the apprenticeship model of the day.[13] The report had numerous implications for the American health care system, including the closure of multiple historically Black medical schools in existence when it was published.[14]

This closing of historically Black medical schools decreased the number of Black physicians in the United States and subsequently perpetuated health disparities faced by groups that have been historically marginalized. According to 2018 data from the American Association of Medical Colleges, only 5% of practicing physicians identified as Black or African American, 5.8% as Hispanic, 1% as Multiple Race, non-Hispanic, 0.3% as American Indian or Alaska Native and 0.1% as Native Hawaiian or other Pacific Islander.[15] This lack of diversity is mirrored in health care leadership. For example, in hospital and medical school leadership, Black physicians make up 4% and 9%, Hispanic physicians make up 2% and 4%, and Asian physicians make up 6% and 13%, respectively.[16]

Racial concordance in health care has been shown to improve health outcomes.[17] One study involving Black men in Oakland, California, found that they sought more preventive services following a free health care screening if the screening was conducted by a Black physician.[18] Other benefits of racial concordance include tangible improvements in things like life expectancy, quality metrics, and infant and maternal health outcomes, as well as better patient-physician connection and communication, increased patient participation in their health care and greater patient satisfaction. A lack of diversity in the workforce translates to inequitable care.

Racism in Medical Research

Race has been used as a biomarker in medical research since before the Civil War. In the 19th and early 20th centuries, researchers attempted to define physical and physiological differences by race, some of which were used to justify the enslavement of people of color, such as the false assertion that Black people's bodies were impervious to pain and some diseases and were better suited for hard labor.[9] Since that time, racial biases have been knowingly and unknowingly incorporated into the design of many studies. Examples of unethical, racially biased studies include the following: an experiment that exposed Alaska Natives to radioactive material without informed consent[19]; the study of Black men from Tuskegee, Alabama, in which treatment for syphilis was deliberately withheld from participants with no informed consent or endpoints[20]; and an American medical research project in which people in Guatemala were intentionally exposed to sexually transmitted infections.[21] Such past abuses have deterred some people from being willing to participate in present-day studies. They have also made it difficult for physicians to connect with some communities or inspire patient confidence in medical research.

The assumption that people of different races are physiologically different in some way has given rise to a practice known as "race-based medicine." Generations of physicians have been trained to make medication choices and even change their determination of disease severity based on a patient's race. For example, the results of poorly designed and executed studies that suggested race-based differences in glomerular filtration rate, or GFR, influenced standard practices until 2020.[22] This prevented countless Black patients from accessing care and delayed necessary transplants, not only impacting health outcomes but also creating unnecessary loss of life.[23] Flawed studies also led to recommendations for differences in first-line hypertension medication based on race, although recent research has provided evidence to counter these studies.[24,25] In addition to the use of race to determine guidelines for hypertension treatment and calculations for estimated GFR, race-based algorithms have been used in assessments for the following: heart failure, cardiac surgery, organ transplant, vaginal birth after cesarean section, urinary tract infection, ureteral stone, rectal cancer, breast

cancer, osteoporosis, fracture risk and pulmonary function.[26] Some race-based guidelines, such as the American Academy of Pediatrics' *Urinary Tract Infection: Clinical Practice Guideline for the Diagnosis and Management of the Initial Urinary Tract Infection (UTI) in Febrile Infants and Children 2 to 24 Months*, have been retired,[27] but others remain in use.

Because race is a social construct and has no physiological impact, studies that use race as a biomarker perpetuate racial health disparities and negatively impact health outcomes. The AAFP's policy on race-based medicine opposes the use of race as a proxy for biology or genetics in clinical evaluation and management and in research.[1] The AAFP also encourages clinicians and researchers to investigate alternative indicators to race to stratify medical risk factors for disease states.

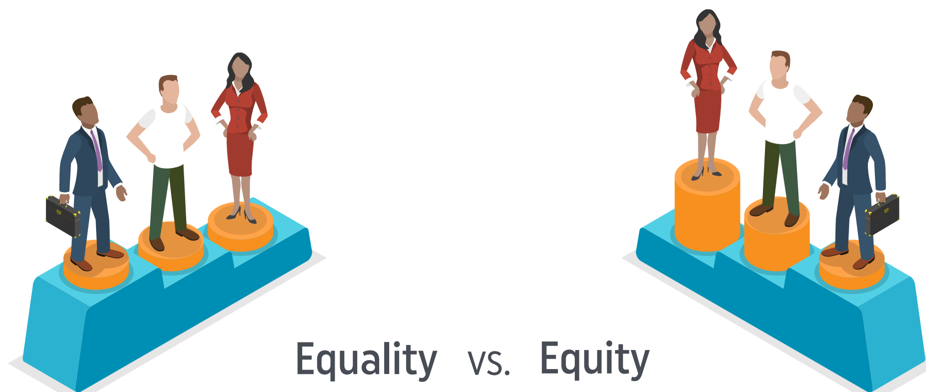
Power 5: Strategies for Becoming an Anti-Racist Physician

In light of the understanding that racism has historically impacted health, physicians are integral to improving health outcomes through anti-racist efforts. This guide is not exhaustive, but it offers a framework of practical strategies that can improve organizational practices and patient outcomes affected by racism (*Figure 1*). While these strategies may be informative individually, each strategy in the framework is necessary for anti-racist medical practice to reach its full potential in overcoming health disparities.

Figure 1. Five Strategies for Becoming an Anti-Racist Physician

Strategy	Description
1. Engage in Internal Reflection and Education	Educate yourself and your practice on racial bias and how current policies and procedures affect health outcomes.
2. Develop Tailor-Made Interventions	Determine the specific needs within your patient population.
3. Co-Design With the Goal in Mind	Co-create an intervention with the population that the intervention targets.
4. Monitor and Measure	Collect and evaluate data to determine the effectiveness of the intervention.
5. Advocate for Change	Influence policy and lawmakers based on findings.

Strategy 1: Engage in Internal Reflection and Education



Educate yourself and your practice on racial bias and how current policies and procedures affect health outcomes.

Equity does not mean equality. Equity emphasizes correcting unfair differences and leveling the playing field. The implications of racism in society, at the hospital/clinic and for patients must be perceived before progress toward racial justice can be made. Racism infiltrates aspects of daily life among those who are oppressed. Self-reflection to assess internal biases and the policies in place is a necessary precursor to creating an intervention that promotes racial and health equity effectively. This involves examining internally facing practices and externally facing practices.[28] Internally facing practices target sustainable organizational change within the organization at individual, interpersonal and organizational levels. Externally facing practices are focused on contributions to justice, transparency and the impact of one's work on the community, partnerships and people of oppressed identities.

Methods to address internally and externally facing practices may include additional training to counter the impact of implicit biases and racism from both individuals and policies. Ample resources are available to help health care systems and/or clinicians implement anti-racist training in a medical practice; however, not all materials have the intended impact. Hudson et al. state that mandatory anti-racist training should "center on educating employees of all levels about what racism is, how it intersects with other forms of oppression, and how it manifests systemically, interpersonally, individually and within the organizational context."[28] Anti-racist training should start with creating a shared set of guidelines about how conversations will proceed. It should also incorporate an understanding of personal identity and how that impacts interactions with other people and with the world, as well as an understanding of differences in the way the world interacts with different people.[29]

One recommendation for those implementing an educational program is to emphasize structural competence.[28,30,31] This includes providing training materials that help clinicians go beyond merely acknowledging the existence of racial health disparities so they understand the ways in which systems and policies lead to such disparities. By inordinately emphasizing health disparities without also emphasizing the sociopolitical context that created them, one can unintentionally perpetuate the falsehood that people of different races are physiologically different. It is also recommended that anti-racist training include information about harm reduction approaches to meaningfully diminish the harm caused

by racist systems and policies.[28,30] Using these approaches empowers clinicians to intervene at community and population levels to prevent the perpetuation of racial health disparities. Evidence has shown that when clinicians have an increased awareness of the effects of racism on health, they are more likely to intervene if they encounter a racist incident or policy.[32] This demonstrates the potential impact of training efforts.

Strategy 2: Develop Tailor-Made Interventions

Determine the specific needs within your patient population.

Current literature demonstrates the disparate health care and health outcomes to which communities of color have attested for decades. Physicians can promote health equity in a practical way by creating interventions aimed at improving health equity within their patient population. The goal is to achieve equity-oriented care at the staff and organizational levels, which requires effort from the entire interprofessional team. One approach is using the Research to Equip Primary Healthcare for Equity, or EQUIP, framework, which focuses on two main components[33]:

1. "Staff education: using standardized educational modes and integration strategies to enhance staff knowledge, attitudes and practices related to equity-oriented care in general, and cultural safety, and trauma- and violence-informed care in particular, and;
2. Organizational integration and tailoring: using a participatory approach, practice facilitation, and catalyst grants to foster shifts in organizational structures, practices and policies to enhance the capacity to deliver equity-oriented care, improve processes of care, and shift key client outcomes."

These components emphasize the need for standardization and specificity. When educating staff, it is important to standardize educational models to ensure shared foundational knowledge related to equity-oriented care. Education on being anti-racist in the clinical environment must include education on trauma- and violence-informed care, cultural safety and contextually tailored care.[33] These approaches to patient care prioritize the patient's reality and center their lived experiences in the clinical encounter. They can also help restore trust within communities of color that have disproportionately high levels of medical mistrust.

Organizational tailoring emphasizes the importance of interventions that reflect the specific needs of the patient population served. For example, an intervention that primarily affects children who receive free school lunch might not be as impactful if a law guaranteeing free lunch for all children within the school district had passed recently. Instead, an intervention to address housing inequities that disproportionately affect immigrants and people from racial and ethnic minority groups could have a greater impact. Conducting a baseline assessment is necessary to determine specific needs, and participation should not be limited to physicians and staff. Patients and community members should also be included to decrease bias and gain deeper perspectives.

Strategies to create a tailor-made intervention can be enhanced with culturally relevant approaches and practices. For example, a practice might serve a community with a large population of undocumented immigrants who do not receive recommended care due to fear of legal consequences. A culturally relevant approach might include recruiting a patient care advocate from this population to act as a liaison between the practice and the community.

The advocate could educate clinicians about relevant cultural factors (e.g., diet and nutrition, home remedies, family dynamics) to inform shared decision-making and increase their understanding of this specific group.

When developing an intervention to address health equity, practices can start by collecting patient data on race, ethnicity and language, or REAL, as defined in *A Toolkit to Advance Racial Health Equity and Primary Care Improvement* (www.chcf.org/wp-content/uploads/2022/07/ToolkitRacialEquityPrimaryCareImprovement.pdf).[34] Collecting REAL data serves as a foundation for providing more equitable care. It is an interprofessional approach that engages staff from diversity, equity and inclusion, patient registration, data analytics, information technology, community outreach, and quality and safety.

Strategy 3: Co-Design With the Goal in Mind

Co-create an intervention with the population that the intervention targets.

When designing an intervention, it is essential to consider root causes and how they affect race rather than making race the basis of the research question.[35] As Hardeman and Karbeah note, the goal is to avoid making "biological assumptions about race rather than understanding its operation as a social and political construct."[35] For example, a research finding of increased asthma in Black children and adolescents merely states a disparity. Interventions should be based on an understanding of how SDOH lead to an unequal distribution of disease and well-being, such as increased asthma rates in neighborhoods that have greater environmental exposures and poor-quality housing.[35]

In order to be solution oriented and emphasize equitable care, it is important to identify the disparity and frame the intervention using language that highlights its goal.[34] An effective way to achieve this when identifying health disparities is to cite social/political determinants of health to describe why specific populations have increased prevalence of certain health conditions instead of making blanket statements about a racial predisposition to those conditions.[36] This approach helps prevent the propagation of race-based medicine in medical education and family medicine practice. It is also important to carefully select language that does not use stereotypes and terms with negative connotations to describe society. For example, there are some racial codes (e.g., "inner city," "thug," "states' rights") that are used to reinforce negative racial stereotypes and ideologies, creating greater disparity and impeding equitable care.[30,37]

The team involved in creating an intervention should include necessary stakeholders such as the physician, staff, patients and community members with lived experiences.[34] People with lived experiences include those who self-identify as part of historically marginalized communities and are affected by racial health inequities and those who will derive the most benefit from equity-focused interventions. In the previous example regarding asthma rates, people affected by poor-quality housing should be included in creating an intervention.

Having a team of diverse health care professionals can help decrease biases and improve outcomes.[12] The team should then recruit diverse patients within the practice to solicit ideas for quality improvement initiatives or interventions that would address their needs. Engaging community members in intervention design forms a bridge between clinicians and the community they serve, thus building trust with patients over time.[38]

One recommended way to facilitate community partnerships is hosting community listening sessions outside of the health care facility in an inviting, central location where participants feel comfortable (e.g., library, community center). Doing so creates a welcoming atmosphere for optimal engagement and builds trust. In addition, providing food and childcare during listening sessions minimizes barriers to community participation.

Compensation for patients and community members involved in co-designing initiatives and interventions is encouraged in order to maintain continuity and show appreciation for their efforts. For example, the Oregon Health & Science University Primary Care Clinic, Richmond, a federally qualified health center in Portland, adopted a shared leadership model between staff and community when launching Community Health and Racial Justice, or CHARJ, an initiative to eliminate diabetes-related racial inequities.[34] Rather than expecting community members to serve as volunteers, the program compensates them for their time and expertise.

Additional Considerations

"Leverage quality and performance improvement programs, structures, and incentives to embed and advance racial health equity."[34]

Consider the timing and relevance of programming and how these factors will impact the goal.

Be careful not to add to the "minority tax" (i.e., additional and often uncompensated burden placed on people of color) when equity initiatives arise.

Recruit patients who frequently no-show to give your team more insight into the perspectives of those impacted by health inequities, including SDOH.[34]

Strategy 4: Monitor and Measure

Collect and evaluate data to determine the effectiveness of the intervention.

After an intervention is created, collecting and evaluating data — whether quantitative or qualitative — is crucial to determine its effectiveness. Registries can be useful for organizing information, creating reports to visualize and track data, and assessing patient needs. As described by Pogones et al., a registry "obtains data from [electronic health records], other electronic data sources, or manual data entry. It then organizes and analyzes the data and presents it in dashboards and reports for easy interpretation. Information can be used to make clinical and administrative decisions, such as reaching out to patients to close care gaps or proactively identifying at-risk patients who may need more intense care so the staff can develop intervention strategies."[39] (See the *FPM* article *Put Your Clinical Data to Work With a Registry* at aafp.org/pubs/fpm/issues/2021/1100/p21.html for more information.)

It is also important to monitor and report concerns within the system that are either created or revealed by the intervention. Doing so can lead to policy changes that promote anti-racist practices in future research and support inclusive spaces for all. Systems can build stakeholders' trust by eliminating barriers to reporting racist policies, practices and

encounters,[32] creating policies that protect those who report and showing a commitment to addressing concerns equitably.

Strategy 5: Advocate for Change

Influence policy and lawmakers based on findings.

Physicians are leaders by training and practice. This extends beyond the exam room and into the sphere of policy and social influence. Anti-racist policies can begin within a physician's own patient population and serve their specific needs. After a successful intervention's health outcomes and impact are analyzed, its scope can be expanded to create regional or national change. Effectively conveying findings and proposing interventions may require advocating through state AAFP chapters and lobbying local legislators. Evidence indicates that those who are most directly affected by social and economic inequities are often the least politically active,[40,41] so advocacy by family physicians is vital to communicate how SDOH affect their patients' health and well-being.

Researchers have identified strategic approaches that are more likely to succeed in building support to address racial disparities.[40] These include framings that "de-emphasized racial inequities but concentrated on widely shared American values (like ingenuity and enhancing opportunity for all) and that linked communities in a sense of shared fate."[40] However, although this approach has been deemed effective, it minimizes health equity and highlights equality. Regardless of the approach, the work to promote and protect health equity is not just in the best interest of groups that have been historically marginalized; rather, it is our responsibility as a country. We cannot become a healthier nation without eliminating racial inequities in health care.

Resources for the Anti-Racist Physician

Being an anti-racist physician is an ongoing practice and a journey that is never completed. The five strategies described in this guide can help family physicians and the systems with which they are connected advance health equity. The following resources for personal, professional and leadership development can also support these efforts.

AAFP Resources

- "Anti-Racism Tools for Change" (aafp.org/cme/all/health-equity/anti-racism.html) – CME available; purchase required
- *It's Time: Six Steps to Creating an Anti-Racist Clinic* (aafp.org/pubs/fpm/issues/2023/0700/antiracist-clinic.html) – CME available
- Health Equity CME (aafp.org/cme/topic/health-equity.html) – CME available
- The EveryONE Project™ (aafp.org/everyone)

Books

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Additional Resources

- Association of American Medical Colleges Anti-Racism Resources (www.aamc.org/about-us/equity-diversity-inclusion/anti-racism-resources)
- The Health Equity Curricular Toolkit (aafp.org/family-physician/patient-care/the-everyone-project/health-equity-tools.html)
- Race Forward (www.raceforward.org)

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Appendix A. Definitions of Key Terms

Bias	"to give a settled and often prejudiced outlook to"[1]
Explicit Bias	"...individuals are aware of their prejudices and attitudes toward certain groups."[2]
Implicit Bias	"a bias or prejudice that is present but not consciously held or recognized"[3]
Diversity	"differences of people with respect to, but not limited by, race, ethnicity, color, religion, background, national or geographic origin, age, gender identity or expression, sexual orientation, ability, education, thoughts, preferences, and skills, among others"[4]
Equity	"The absence of avoidable and unfair differences among individuals or groups of people. The playing field has been leveled so that everyone has a fair opportunity to attain their full potential, and no one is disadvantaged from achieving this potential for any reason."[4]

Appendix A. Definitions of Key Terms (continued)

Ethnicity	"The quality or fact of belonging to a population group or subgroup made up of people who share a common cultural background or descent."[5]
Health Disparities	"… preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations."[6]
Health Equity	"…achieved when every person has the opportunity to attain [their] full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances."[7]
Inclusion	"Equitable opportunities are provided for participation and sharing that demonstrate everyone is equally valued and [feels] welcome."[4]
Intersectionality	"the complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups"[8]
Oppression	"unjust or cruel exercise of authority or power"[9]
Power	"possession of control, authority, or influence over others"[10]
Prejudice	"preconceived judgment or opinion; an adverse opinion or leaning formed without just grounds or before sufficient knowledge"[11]
Privilege	"a right or immunity granted as a peculiar benefit, advantage, or favor"[12] and "the advantage that…powerful people have over other people in a society"[13]
Race	"…a social construct used to group people…[race] divides human populations into groups often based on physical appearance, social factors and cultural backgrounds."[14]
Racism	"…a system that categorizes people based on race, color, ethnicity and culture to differentially allocate societal goods and resources in a way that unfairly disadvantages some, while without merit, rewards others."[15]
Cultural Racism	"…societal beliefs and customs that promote the assumption that the products of white culture (e.g., language, traditions, appearance) are superior to those of non-white cultures."[16]
Individual Racism	"…private beliefs and biases about race that reside inside individuals' minds and bodies"[17]
Institutional Racism	"…occurs within institutions. It involves unjust policies, practices, procedures, and outcomes that work better for [white] people than people of color, whether intentional or not."[17]
Interpersonal Racism	"…between individuals — the bias, bigotry, and discrimination based on race"[17]

Structural Racism	"...racial inequities across institutions, policies, social structures, history, and culture. These inequities are deeply rooted and embedded in our history and culture, and our economic, political, and legal systems."[17]
Systemic Racism	"the oppression of a racial group to the advantage of another as perpetuated by inequity within interconnected systems"[18]
Social Categorization in Medicine	Concept that describes the way in which biases against patient populations are perpetuated in medical education[19]
Social Determinants of Health	"...the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[20]

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