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Preamble

The field of equity, like all other scholarly domains, has developed specific norms that convey authenticity, precision and meaning. Just as the general structure of a business document varies from that of a physics document, so too is the case with an equity document. One example is the inclusion of a "Land and Labor Acknowledgement" like the one below. It is common that discussions in the field of equity begin with the recognition that our current state is built on the land and labor of others in ways that violated the fundamental principles of equity.

The Association of American Medical Colleges' headquarters is located in Washington, D.C., the traditional homelands of the Nacotchtank, Piscataway and Pamunkey people. The American Medical Association's headquarters is located in the Chicago area on taken ancestral lands of indigenous tribes, such as the Council of the Three Fires, composed of the Ojibwe, Odawa and Potawatomi Nations, as well as the Miami, Ho-Chunk, Menominee, Sac, Fox, Kickapoo and Illinois Nations.

With more than 65,000 Native Americans and Indigenous peoples represented in 175 different tribes, Chicago today has the third-largest urban Indigenous population in the U.S. More than 4,000 American Indians and Indigenous peoples still reside in the District of Columbia. We acknowledge their ancestors were forced out by colonization, genocide, disease and war.

The AAMC and AMA also acknowledge the extraction of brilliance, energy and life for labor forced upon millions of people of African descent for more than 400 years.

We recognize the significant contributions that Native Americans/Indigenous peoples and people of African descent have made to this country, particularly to the fields of medicine and science. We celebrate the resilience and strength that all Indigenous people and descendants of Africa have shown in this country and worldwide. Their land, labor, bodies and minds—and those from other historically marginalized people and groups over the course of our nation's history—have contributed to the wealth of this nation and, by extension, to the AAMC and AMA.

The AAMC and AMA also mourn the loss of life and liberty of millions of others who have historically been oppressed, exploited, excluded, segregated, experimented upon and dehumanized in the U.S. over centuries, and acknowledges their historical trauma and the long-lasting impact this has had on them as an individual, their families and their communities.

The AAMC and AMA understand that while the goal of health equity is inclusive of all communities, it cannot be achieved without explicit recognition and reconciliation of our country's twin, fundamental injustices of genocide and forced labor. We must remember that we carry our ancestors in us, and we are continually called to be better as we lead this work toward the pursuit of racial justice, equity and liberation.

Contents

It is critical to address all areas of marginalization and inequity due to sexism, class oppression, homophobia, xenophobia and ableism. Yet conversations about race and racism tend to be some of the most di cult for people in this country to participate in for numerous reasons, including a lack of knowledge or shared analysis of its historical and current underpinnings, as well as outright resistance and denial that racism exists. Given the deep divides that exist between groups in the United States, understanding and empathy can be extremely challenging for many because of an inability to really "walk a mile in another's shoes" in a racialized sense. Collectively, we have an opportunity and obligation to overcome these ssures and create spaces for understanding and healing.

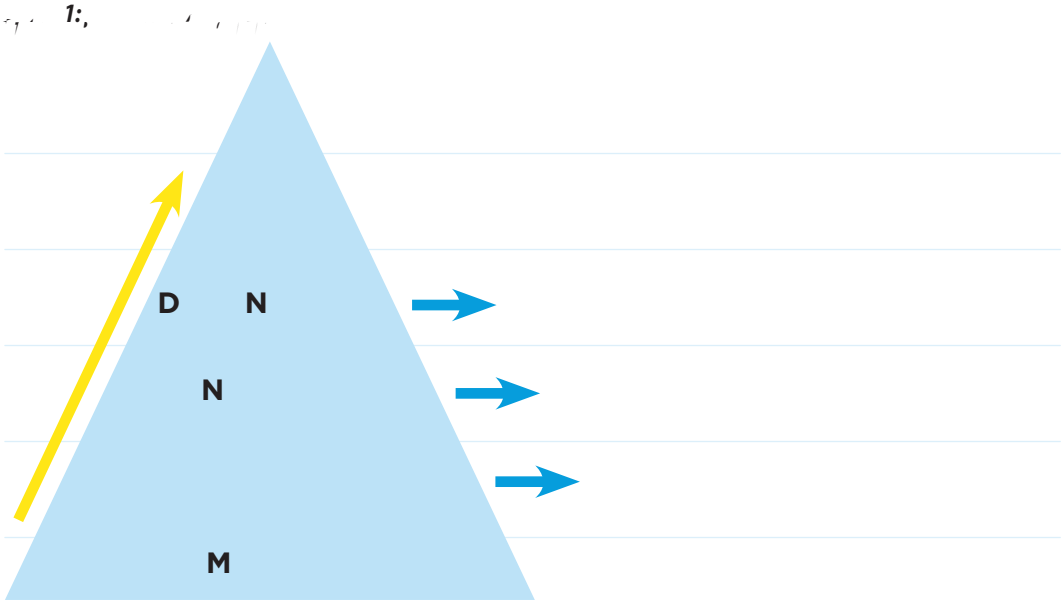
Introduction

The □eld of health equity, as a scholarly domain and as a central issue in medicine, has evolved a great deal in recent years. A lot has been learned, and important progress has been made; yet there is still much that is being debated. Just as we would when exploring any new topic or area of study, when we want to learn more about the science

confronting the mounting evidence of the health e□ects of structural racism, while grappling with understanding intersecting, complex, and deeply entrenched "systems of power and oppression," including white supremacy (the false notion of a hierarchy of human value based on skin color with white being considered as supreme), classism, homophobia, xenophobia, ableism and sexism.[7]*

Health equity work requires an acknowledgment and reconsideration of previously taken for granted beliefs about health (and how it is produced), the health care and public health systems (and how they work), and society (and how it is set up to advantage some and disadvantage others). Central to this work is a consideration of our language, and the narratives that shape our thinking. As we explore in this guide, *dominant* narratives (also called *malignant* narratives), particularly those about "race," individualism and meritocracy, as well as narratives surrounding medicine itself, limit our understanding of the root causes of health inequities. Dominant narratives create harm, undermining public health and the advancement of health equity; they must be named, disrupted and corrected.

Narratives, stories and language are, of course, deeply interconnected. Importantly, opportunity exists at each level of this narrative ecosystem (see Figure 1) to either perpetuate the status quo or to challenge and dismantle existing injustice.



Source: *Guide to Counter-Narrating the Attacks on Critical Race Theory*.[8]

Race Forward's model of a narrative ecosystem (illustrated in Figure 1) is straightforward but powerful: at the most abstract level, we have deeply held values that are repeated and reproduced over time and often not easily visible to many of us. From these narratives, we derive stories—accounts of events or experiences. Stories are told with words and images.[9] As Race Forward explains, "when our stories and messages align with the narratives we want to elevate, we create impact."[8]

* Throughout this document, footnotes will present links to relevant AMA policy. These policies may be found in the AMA Policy Finder: https://policysearch.ama-assn.org. Grounded in health equity, this document is most closely connected to Plan for Continued Progress Toward Health Equity H-180.944, which states: "Health equity, de□ned as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; in□uencing determinants of health; and voicing and modeling commitment to health equity."

Much is at stake in whose narratives dominate, receive traction and thrive. Narratives grounded in white supremacy and sustaining structural racism, for example, perpetuate cumulative disadvantage for some populations and cumulative advantage for white people, and especially white men. Patriarchal narratives enforce rigidly de□ned traditional norms, and reinforce inequities based on gender. Narratives that uncritically center meritocracy and individualism render invisible the very real constraints generated and reinforced by poverty, discrimination and ultimately exclusion. Yet a rich tradition of work in health equity and related □elds, including critical race theory (de□ned in the glossary), gender studies, disability studies, as well as scholarship from social medicine, gives us a foundation for an alternative narrative, one that challenges the status quo, one that moves health care towards justice.

Part 1: Language for promoting health equity

This section of the guide sets out to help the reader recognize the limitations and harmful consequences of some commonly used words and phrases. In their place, we o□er equity-centered alternatives. To be sure, we acknowledge that language evolves over time, and words come in and out of favor. Context also matters, and words that might be appropriate in some circumstances may not be appropriate in others. For example, in some circles the word "Latinx" is appreciated; in other circles, the word lacks meaning and alternatives like Latina, Latino or Hispanic are preferred. We must be mindful, in all our communication, of the norms of the community as well as social developments, as the meanings of words and their usage change over time. Patient and community engagement are foundational elements for building and maintaining an equity lens in any communication. But in all cases, pursuing equity requires disavowing words that are rooted in systems of power that reinforce discrimination and exclusion. For example, the word "Caucasian" has remained in many people's vocabulary, despite the well-documented racist origins of the term.[17] And the word "minority" is widely used, but for reasons we will examine, it can be pejorative. We explore these and many other words below.

Our primary goal is not to provide a de□nitive list of "correct" terms, but rather, to give some guidance on equity-focused, person-□rst language. For example, one might commonly describe someone as "a diabetic." A person-□rst alternative would be "a person living with diabetes." Or consider the commonly used description of a person as "homeless." An equity-focused alternative would be "a person experiencing homelessness." In these simple examples, we can start to recognize the power of language to frame our thinking; equity-focused, person-□rst language seeks to center the lived experience of people and communities without reinforcing labels, objecti□cation, stigmatization and marginalization. Along these lines—consider the ways that the word "community" is sometimes used, suggesting that "the community" is monolithic. Words re□ect our thinking and shape our thinking; it is to our bene□t to pause to consider and reconsider their meanings.

Some of our recommendations echo the recently published guidance from the CDC, in its "Health Equity Guiding Principles for Unbiased, Inclusive Communication," which lays out □ve key principles:

1. Avoid use of adjectives such as "vulnerable" and "high-risk."
2. Avoid dehumanizing language. Use person-□rst language instead.
3. Remember that there are many types of subpopulations.
4. Avoid saying "target," "tackle," "combat" or other terms with violent connotation when referring to people, groups or communities.
5. Avoid unintentional blaming.

These principles are explored in greater depth in Table 1, with guidance for equity-focused alternatives.

Building on these principles, we offer alternatives for at-times problematic words commonly used in health care (see Table 2). These are words we have read and heard; words that have the potential to create and perpetuate harm. Additionally, Part 3 of the guide provides a larger glossary of key terms—from *antiracist* to *gender* to *weathering*. The list below is not meant to be exhaustive, but to promote critical reflection on language and word choice. In many cases, person-first language will be preferred. Yet in other cases, the cause of equity and justice will be better served with adjective language. For example, some disability activist groups speak against openly objectifying language (i.e., “an autistic”) but actually promote adjective language rather than person-first (i.e., “autistic people” rather than “people with autism”). For some (but not all) disability activists, creating adjectives is preferred to signify a sense of identity rather than a more medicalized “condition.”

Again, context will matter. Our responsibility is to develop and embody critical consciousness and to be aware of how our choices of words reinforce dominant narratives, and when they open possibilities for moving toward equity (see Part 2).

The intended audience is another consideration to keep in mind. Consider who may be reading what you write and how effective different words might be in delivering your intended message. We recognize that equity-focused language may create discomfort for some people and some institutions, particularly those stepped in dominant narratives. Narrative change work almost always creates resistance, particularly if the work is likely to disrupt the status quo. Yet it is important to do this work, *even in the face of resistance*. Embracing discomfort and disruption is a part of dealing with resistance, and perhaps an inevitable part of progress and change.

[illegible] 2: [illegible]

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Commonl. sed		

Commonly used	Equity-focused alternative	Requirements

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Part 2: Why narratives matter

Narratives can be understood as collective stories, or systems of meaning. These stories are woven into the fabric of everyday life; they circulate widely and are embedded in our national psyche. They "provide the necessary mental models, patterns, and beliefs to make sense of the world and our place within it."[38] They shape our language, our thinking, and our actions. They are mostly taken for granted and accepted as natural, when in fact they are not. They are expressed in a wide variety of formats, including legal codes, the arts, mass media, corporate reports and scientific literature.

Narratives are embedded in the structure of the health care system, and in the ways in which we think about patients, families, communities and neighborhoods we serve—and even ourselves. For example, certain narratives guide physicians' and other health care providers' thinking about "non-compliance" (itself an outdated term rooted in a power differential that places blame on patients), just as other narratives guide their thinking

This guide discusses how dominant narratives obscure historical legacies and harmful power structures that a□ect people's well-being. Dominant narratives serve to uphold social and economic relations that privilege some and marginalize others. They shape our thinking and assessment of the world around us. They determine who we "see" and whose needs are and aren't prioritized. Importantly, dominant narratives shape our understanding of what we deem possible and not possible.

One important way to make narratives visible is to consider the language we use in our work. Take, for example, the widely used term "vulnerable population," a term often used to describe groups that exhibit increased susceptibility to adverse health outcomes.[§] We even describe individuals as vulnerable or not vulnerable, often based on their socioeconomic status or neighborhoods in which people live. If we pause to examine our unconscious narrative, we can see that vulnerability can be understood in very di□erent ways. In this case, it is used as a characteristic of people or groups—as something they "have."

But what if we shift the narrative from an individualistic lens to an equity lens? That leads to questions directed toward the structural origins of vulnerability.[40,41] Instead of stigmatizing individuals and communities for being vulnerable, we begin to recognize the conditions and power relations that createe2 /L an8ttim(abilit)-;malLang (en-oclner)5 (aeSd097 BDC BT10.5 0 0 10.5 1

These examples reveal a deeper point: our language reflects underlying systems of power. Ibram X. Kendi, in Stamped from the Beginning: *The Definitive History of Racist Ideas in America*, describes how racist ideas grow *out* of discriminatory policies, not the other way around.[42] Ideas, expressed in words and narratives, are grounded in economic and political power that advantage some and disadvantage others.

Reframing our language in this way (for example, rethinking our use of "vulnerability") opens up possibilities for reimagining health interventions; it shifts the focus from the personal/behavioral to the structural. Jonathan Metzl and Helena Hansen describe this as "structural competence," the trained ability to understand how issues typically defined clinically as symptoms, attitudes or diseases (e.g., depression, hypertension, obesity, smoking, medication "non-compliance," and even trauma) also represent the downstream manifestations of a number of upstream structural drivers: social inequities, institutional policies and living conditions.[22] There are now a growing set of tools for assessing "structural vulnerability" in health care settings and a growing commitment among many health systems to push upstream to address the root causes of health inequities in their communities.[41]

Dominant narratives reflect the values and interests of the dominant group—white, wealthy, hetero-, able-bodied, male, Christian, U.S.-born. Challenging dominant narratives often involves, indeed requires, re-thinking language and word choice from the perspective of those outside this group. Twenty years ago, for example, *health equity* was a term rarely used in the United States. Instead, we often used *health disparities*, a term now widely recognized as limited to a description of difference. Health *inequities*, in contrast, came to be defined as health differences that are unjust, avoidable, unnecessary, and unfair—no longer a simple calculus of difference, but an assessment based on a value judgment.[2] The change in terminology was important, signaling a shift in our understanding and interpretation of the data. The shift in narrative ushered social justice concerns from the margins to the center.

Generally, narratives are collections of related, shared stories or explanations that circulate in society and produce systems of meaning enabling people to make sense of the world and how it works.[9] They provide shared explanations of who we are as a nation and what functions government should perform. Because these narratives become inscribed in our consciousness from an early age, often as common sense, *who is telling the stories* is not always clear.

Dominant narratives are deeply rooted, ingrained, widespread stories, explanations or cultural practices that give preference to the interests of society's most powerful social groups, often based on race, class, gender, sexual orientation, physical ability and other characteristics used to oppress other groups. For example, dominant narratives explain economic inequities as the result of market forces, or the large gaps in life expectancy found among different population groups as due to individual behavior. These narratives are powerful because they can influence the legitimacy of public agendas and acceptable policy. Subconsciously reinforcing and repeating stories over time can sustain inequity by obscuring its causes (and responsible parties), *making injustice appear natural and inevitable*. Consider the examples in Table 4, drawn from the work of the National Association of County and City Health Officials (NACCHO), in its influential report, "Advancing Public Narrative for Health Equity & Social Justice":

[illegible] 4: [illegible]

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D [illegible]	C [illegible]
D [illegible]	D [illegible] A [illegible] D [illegible]
D [illegible]	C [illegible]
D [illegible]	[illegible]
D [illegible]	F [illegible]
D [illegible]	C [illegible]

Source: NACCHO, "Advancing Public Narrative for Health Equity & Social Justice" report.

Dominant narratives are found everywhere in culture, not only in language. They exist in the public consciousness and cultural memory, reinforced in stories, images, symbols, myths, practices, customs, art, mass media, textbooks, □ction and more. Often resistant to change, they become normalized and unquestioned, like stories about the founding of the United States, a slave-holding society where only propertied white men could vote. Dominant narratives protect and advance the interests of privileged social groups, often dividing populations with common concerns, and obscuring alternative visions of what is possible.

The important purpose that underlies the close examination of dominant narratives is to demystify and correct distortions of reality, thereby revealing the interests and history behind structures of power that perpetuate social injustice. One important aspect of health equity work is to create the conditions for telling the stories of those who have been excluded.

Yet, narratives are not static. They are constantly changing due to contradictions and resistance, and require continuous validation. Earlier in this guide, we introduced two medical cases: a 44-year-old man with acute back pain and a 60-year-old woman presenting at a community hospital with a lump in her breast.[14,39] Both situations could be

interpreted within the dominant narrative, focusing on biomedical issues and individual behaviors. Yet both situations also called for a much deeper and nuanced analysis to fully understand the dynamics of *structural violence* at play.[43] In both cases, one could change the narrative and generate alternative explanations (and possible solutions) for the cases.

Consider, for example, the overwhelming focus on changing individual behavior to improve health, mostly avoiding the social and economic conditions which generate poor health outcomes—this individualistic focus re□ects dominant narratives.[3 ¶] Or the narratives often present in medical discourse around patient "non-compliance." Non-compliance is often used to blame patients for not following through with their health plan—ignoring the signi□cant barriers faced by patients in their lives, from not having enough money to pay for their medications, or not having the capability to take time o□ work, or not being able to secure a□ordable childcare to participate in an activity or follow up appointment. Conventional and equity-focused root-cause narratives are illustrated in Table 5:

5: C

Con entional	Re ision
A	D A

Camara Jones defines race as "a socially constructed way of grouping people, based on skin color and other apparent physical differences, which has no genetic or scientific basis."[45] Yet in many aspects of medicine, race continues to be used as a biological concept.[13] The practice of using race as a biological construct (racial essentialism) results in harm for

Our work must recognize how systems of power intersect to create and reinforce inequities, particularly based on race. This means that we must invest in data infrastructure to collect race and ethnicity data, while continuing to challenge and disavow essentialist or biological explanations of race-based differences. In other words, we need race and ethnicity data to fully understand, challenge and overcome racial inequities in society.

We lead with race because history and the evidence compel us to do so. Racial inequities, representing some of the largest gaps amongst populations in this country, exist and persist in every system examined across the country: health care, education, criminal justice, employment and housing.[7] Conversations about race and racism also tend to be some of the most difficult for people in this country to participate in for numerous reasons, including a lack of knowledge or shared analysis of its historical and current underpinnings, as well as outright resistance and denial that racism exists. Given the deep divides that exist between groups in the United States, understanding and empathy can be extremely challenging for many because of an inability to really "walk a mile in another's shoes" in a racialized sense. This creates fissures that have to be overcome when seeking to achieve a space of understanding. Engaging in anti-racist work requires both a personal commitment to an internal process of working through the trappings of white supremacy and dominant narratives.

We recognize that across other dimensions of marginalization (including gender, gender identity, sexual orientation, disability, age, class/socioeconomic status, citizenship status and language), structural racism remains a significant injustice. It is critical to address all areas of marginalization and inequity due to sexism, class oppression, homophobia, xenophobia and ableism. This recognition calls for us to apply an intersectional approach, a "race AND _____" approach, in which we continually acknowledge that these overlapping identities create unique modes of advantage and oppression.

Individualism is a philosophy and group of ideas, expressed in symbols, practices, and stories that supports a belief that self-sufficient individuals are rational beings that freely make consumer-like choices, independent of political influences, living conditions or historical context. Among these ideas is the concept of meritocracy, a social system in which advancement in society is based on an individual's capabilities and merits rather than on the basis of family, wealth or social background. Individualism is problematic in obscuring the dynamics of group domination, especially socioeconomic privilege and racism.[58]

societal, structural inequalities.[3,61,62] We argue that much can be gained by shifting this narrative, from the individual to the structural, in order to more fully understand the root causes of health inequities in our society.

The p rpose of a health eq it-based narrati e

There are many dominant narratives that attribute health to personal choices (weight, drug/alcohol abuse, preventive health care) without taking into consideration equity in the greater society. However, it is almost impossible to be or stay healthy in an *unhealthy environment*. Consider the health e□ects of living in chronically disinvested neighborhoods, with poor quality and unsafe housing, with limited options for exercise and healthy foods, expensive or unreliable public transportation, a dearth of pharmacies and an overabundance of fast-food outlets. The harmful e□ects of these characteristics are the basis of the social determinants of health model, as well as newer models that go even further "upstream" to the root causes of health inequities.

We have seen that a dominant narrative in health care regards health as a personal responsibility. The prominent social epidemiologist Nancy Krieger calls this the "medical and lifestyle" explanation of health inequities.[3] It focuses on biological explanations of disease, treatable and amendable through health care and individual-level behavior change. Krieger argues that this narrative is limited and ignores social context, leading to a simplistic understanding of the causes of health inequities. This dominant narrative does not take into consideration social justice, but rather, looks at people and/or communities failing or succeeding with no bearing of responsibility by the systems and structures of power in□uencing their lives.

A health equity-based public narrative would:

- Focus attention on *inequitable systems, hierarchies, social structure, power relations, and institutional practices* to reveal the sources of inequalities and the mechanisms that sustain them.
- Avoid both blaming individuals for their condition or assuming that inequity can be resolved through programmatic □xes that ignore the social responsibility of corporations and government agencies.
- Encourage public dialogue on structural racism and all forms of oppression and inequity to encourage a broad public response.
- Foster e□orts to strengthen community-driven initiatives that fundamentally improve well-being

A health equity narrative grounded in equity and a social justice framework also would:

- Provide possibilities and the space to re□ect, engage and fearlessly advance possibilities for a more just society.
- Highlight examples drawing on experiences from throughout the world.
- Expose the political roots underlying apparently "natural" economic arrangements, such as property rights, market conditions, gentri□cation, oligopolies and low wage rates.

- Develop from collectively recognizing and denouncing oppression in all its forms.
- Make visible not only the injustice, but the varied voices of those oppressed, and their perspectives on social justice.
- Redistribute power and resources to those most in need.

Changing the narrati e

Shifting the dominant narrative about health equity is a daunting task. But it is both possible and vital for the betterment of public health. Many people and organizations have already started this work, as illustrated in the landmark report, “Build f/GS1 gs4l3(4.)y people ial justice.

CDC's "Health Equity Guiding Principles for Inclusive Communication" (available at https://www.cdc.gov/healthcommunication/Health_Equity.html*) toolkit provides principles, resources, and speci c suggestions for equity-focused communication and deeply informed the development of this document.*

The AMA's "Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity" envisions a nation in which all people live in thriving communities where resources work well; systems are equitable and create no harm nor exacerbate existing harms; where everyone has the power, conditions, resources and opportunities to achieve optimal health; and all physicians are equipped with the consciousness, tools and resources to confront inequities and dismantle white supremacy, racism and other forms of exclusion.[65]

The AAMC Center for Health Justice, which launched in the fall of 2021, will work with community members across the country, alongside partners from the multiple sectors that serve them, to co-develop evidence and action to shift policy and practice toward health equity and justice.[66] *It will support research to elucidate promising physician and health care worker practices to improve health, and especially to promote health care equity. This begins in the medical education curriculum and should lead to measurable impact.*[67] *Within the "Competencies Across the Learning Continuum Series," The AAMC has developed health equity competencies within Quality, Improvement and Patient Safety, Telehealth, and forthcoming are competencies on Diversity, Equity & Inclusion.*[68] *This guide, the competencies listed, and other tools can help guide curricular and professional development activities for physicians at any level.*

[illegible]

A term used to "describe someone who does not identify as having a disability. Some members of the disability community oppose its use because it implies that all people with disabilities lack "able bodies" or the ability to use their bodies well. They may prefer "non-disabled" or "enabled" as being more accurate."[69] Some disability rights groups use the term "temporarily able-bodied" with the acknowledgment that many people who today are able-bodied will remain so throughout their lives.

[illegible]

Discrimination of people with disabilities based on the belief that typical abilities

medical conditions, romantic inclinations. Asexually identified individuals can experience marginalization in society.[73]

[illegible]

Focuses on the assets of communities rather than their needs, deficits or problems; focuses on what is working well to support the health and well-being of individuals, populations and communities. This perspective recognizes the competencies and resources people possess to exert their own empowerment. It asserts that people are capable of solving problems and learning new skills; they are part of the process, not just dependent on professional resources.[74]

[illegible]

One who is expressing the racist idea that a racial group is culturally or behaviorally inferior and is supporting cultural or behavioral enrichment programs to develop that racial group with the goal that the group would then be better able to blend within the dominant group.[72]

[illegible]

Model of health employed since the mid-19th century that emphasizes biological factors in the understanding and treatment of diseases, excluding environmental and social influences.[75] It provides the foundational assumptions that shape the context for health professionals to diagnose and treat diseases in most Western countries. This individualized, reductionist approach neglects other critical components, generally blaming individuals for their condition instead of acknowledging long-term, intersecting structural influences associated with social injustice.

[illegible]

The fear and hatred of, or discomfort with, people who love and are sexually attracted to more than one gender.[76] Related to bisexual erasure, the tendency to ignore or deny the existence of bisexuality.

[illegible]

A person emotionally, romantically or sexually attracted to more than one sex, gender or gender identity though not necessarily simultaneously, in the same way or to the same degree. Sometimes used interchangeably with pansexual.[76]

[illegible]

Uplifting, trusting, and valuing the lived experiences of the people most impacted by the issue(s) and inequity(ies) you want to address; the process of centering the voices of those who have been historically marginalized.

[illegible]

Gender identity in which a person's experiences of their gender matches the gender and sex they were assigned at birth (i.e., a cisgender man or cis man).

[illegible]

Socially constructed assumption that everyone's gender matches their biological sex, and that this assumption is the norm from which all other gender identities deviate.

[illegible]

A discriminatory system that oppresses and marginalizes people whose gender identity and/or gender expression (e.g., transgender, non-binary, etc.) fall outside the normative social constructions of gender (i.e., the gender binary). This system confers advantages to those aligned with normative gender norms, roles, expressions, and identity by privileging the binary social structure through representation, policies, practices, and structures that reflect and accommodate their rights, needs and lived experience. An example of cissexism is refusing to recognize the rights of transgender people

discrimination is no longer a central force a□ecting minorities' life opportunities today.)[53]

Discrimination based on skin color, which often privileges lighter-skinned people within a racial group, positioning people with darker complexions at the bottom of the racial hierarchy.[70]

The process in which a person □rst acknowledges, accepts and appreciates their sexual orientation or gender identity and begins to share that with others.[76]

Born out of both legal studies and education scholarship, this is a framework that centers experiential knowledge, challenges dominant ideology, and mobilizes interdisciplinary action and research in order to uncover inequalities related to race and racism and other intersectional identities and/or experiences.

Set of shared attitudes, values, goals and practices that characterize an institution, organization or group. Culture

[illegible]

Explanations or stories that support and reflect a dominant social group's interests and ideologies. They can be used to describe the dominant culture's explanation for societal events, guiding perceived reality.

[illegible]

Upstream refers to acknowledging and addressing the structural, societal, community and individual-level factors that influence health. Whereas downstream refers to the dominant approach of treating individual-level factors and/or contributors without wholly addressing structural, societal and community factors. "Moving upstream" involves continuously seeking to address the root causes of health inequities and improving the structural and social drivers of health for all people.

[illegible]

A core concept in ecosocial theory, used to describe the idea that we literally incorporate the world in which we live biologically.[84,85] Nancy Krieger notes that it is a "… deliberate corrective to dominant disembodied and decontextualized accounts of 'genes' 'behaviors,' and

According to James Petras, often a "euphemism implying free, fair and equal competition in unregulated markets [ignoring] the reality of market domination by monopolies and oligopolies … 'Free' refers speci□cally to the absence of public regulations and state intervention to defend workers safety as well as consumer and environmental protection."[88] This concept cannot be found on a large scale in practice since modern markets rely on rules, regulations, property rights and enforceable laws, including those governing corporations, partnerships, foreign exchange, trade, etc. Markets are also deeply involved in political struggle, based on asymmetrical relations that give near monopoly power to some, including in□uence over the infrastructure in which markets operate.

A person who is emotionally, romantically or sexually attracted to members of the same gender. Men, women and nonbinary people may use this term to describe themselves.[76]

Conventionally, refers to the "social, psychological, and emotional traits, attitudes, norms and behaviors, often in□uenced by society's expectations, that classify someone as man, woman, both, or neither."[36] A term associated primarily with social and cultural di□erences that more broadly denotes a range of identities that do not correspond to established ideas of the cisgender male and female. Self-determination of gender identities has signi□cant implications for health outcomes.

According to the WHO, "gender has implications for health across the course of a person's life in terms of norms, roles and relations. It in□uences a person's risk-taking and health-seeking behaviors, exposure to health risks and vulnerability to diseases. Gender shapes everyone's experience of health care, in terms of a□ordability, access and use of services and products, and interaction with healthcare providers."[89]

Classi□cation of gender into two distinct, opposite, and separate forms of masculine and feminine, whether through social system or cultural belief. This is a widely used but oppressive model that erases the identities of people who fall outside of it.

Psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity.

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Health "inequities," in contrast, are explicitly defined as health differences that are avoidable, unnecessary, unfair and unjust.[2] As used in public health and medicine, the term health disparities often ignores the historical context, political processes and unjust nature of some health outcomes, thereby preventing a structural analysis of root causes.

[illegible]

Defined by the WHO as "the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. 'Health equity' or 'equity in health' implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential."[10]

Other valuable definitions include that of Paula Braveman: "Health equity is the principle underlying a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions. … Health equity means social justice in health (i.e., no one is denied the possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged)."[27] Another is from Camara Jones: "Health equity is assurance of the conditions for optimal health for all people. Achieving health equity requires valuing all individuals and populations equally recognizing and rectifying historical injustice, and providing resources according to need."[91]

Health equity, defined as optimal health for all, is a goal the AMA and AAMC will work toward by advocating for health care access, research and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

[illegible]

Used to describe the ability of individuals to locate, understand, interpret, and apply health information to guide their decisions and behavior. For the past three decades, the term has been used as an individual-level characteristic, an attribute of a person—someone has low/high levels of health literacy. A variety of research instruments are available to measure health literacy in this way.[92] This term has received substantial criticism in recent years for its undue and harmful focus on individuals, neglecting the complex system of communication that occurs in all aspects of health care. The U.S. Department of Health and Human Services has proposed to refine health literacy as a systems level characteristic: "Health literacy occurs when a society provides accurate health information and services that people can easily find, understand, and use to inform their decisions and actions."[93] This new definition acknowledges that literacy is not a skill that a person has or does not have, but rather, is the outcome of an effective

Di erences in health outcomes that are systematic, avoidable, unnecessary, unfair and unjust.[2,27]

Collective and complex trauma in icted on a group who share a speci c identity or a liation.[95] /Span < /MCID 82 BDC BT10.5 0 0 10.5 168.9739 594.75 T0 K4 w /GS0 gsq 1 0 0 1 108

hormones, chromosomes, etc.) do not align with medically de□ned and socially expected notions of male and female. It is seen as both an identity and a "condition" and can vary by person. Viewing intersex as a condition can be problematic as is often "treated" medically in infancy (i.e., the infant's sex is assigned, and they are socialized to embody the corresponding gender identity as expected). Some argue intersex infants should not undergo medically unnecessary surgical procedures to "correct" the condition, thereby mitigating further stigmatization, reinforcement of the binary system, and medicalizing normative human variation.[99] The terms "di□erences of sexual development" or "disorders of sexual development" may sometimes also be used especially in the medical setting. Intersex is formally known as hermaphrodite or hermaphroditic—terms now largely out of use and considered o□ensive.

Describes a future state where the root causes (e.g., racism, sexism, class oppression) of inequity have been dismantled and barriers have been removed. It is an achievable goal that requires the sustained focus, investment, and energy of leaders and communities working together holding each other accountable to redesign our structures, policies, and practices to deliver the high-quality and safest possible conditions that allows for everyone to reach their highest potential.

A relatively new term that to describe people who are of or relate to Latin American origin or descent. It is a gender-neutral and nonbinary alternative to Latina/Latino. While awareness and acceptance of Latinx is thought to be low, there is growing acceptance of the term Latinx in the U.S., due to its inclusivity. Of note, many Hispanic, Latina/Latino/Latinx members prefer to identify using other terms including national or ethnic origin (i.e., Argentinian, Mexican, Puerto Rican). Furthermore, other terms like Chicano or Chicana are used historically and politically to signal social justice and advocacy inclusion and people still identify with this term. Finally, the term Spanish is used regionally to identify descendants of Spain who also have other ethnic and national origins. Preferred terms vary regionally. Best practice is to consult the speci□c communities involved in discussion to ask their preference.

A woman who is emotionally, romantically or sexually attracted to other women. People of many di□erent gender identities may use this term to describe themselves.

An acronym for "lesbian, gay, bisexual, transgender and queer." Other forms of the term include LGBTQIA "lesbian, gay, transgender, queer or questioning, intersex, and asexual," LGBTQ+ to recognize the growing understanding of sex and gender and to include allies, and LGBTQQIP2SAA, for "lesbian, gay, bisexual, transgender, questioning, queer, intersex, pansexual, two-spirit (2S), androgynous and asexual." It is a developing term, shifting regularly.

Process experienced by those under- or unemployed or in poverty, unable to participate economically or socially in society, including the labor market, who thereby su□er material as well as social deprivation.[100]

Based on a functional analysis of the body as a machine to be □xed in order to conform with normative values.[101,102] The medical model of disability views

disability as a "problem" that belongs to the person with the disability. It stands in contrast to the social model of disability, which focuses on systemic barriers, derogatory attitudes, and social exclusion (intentional or inadvertent), which make it di□cult or impossible for individuals with impairments to attain their valued functionings.

Describes someone who has the potential for emotional, romantic or sexual attraction to people of any gender though not necessarily simultaneously, in the same way or to the same degree. Sometimes used interchangeably with bisexual.[76]

Systematic domination by men. A system of society or government in which men hold the power and women are largely

Realizing health equity depends on being able to in□uence, shape, and secure healthy living and working conditions by participation in decision-making a□ecting those conditions. That requires enhancing political equality by increasing the political power of historically marginalized and exploited populations to gain knowledge, autonomy in employment conditions, and social respectability. Powerlessness is reinforced through social isolation and the growing concentration of power corporations have in directing society.

Traditionally, in public health, measures to prevent the occurrence of disease and illness that are focused on changing individual (risky) behavior through health promotion policies or marketing activities, primarily associated with making choices. Also refers to broad types of regulation (of environments, housing, medications, support for vaccinations) to ensure the public is adequately protected. Although prophylactic in nature, these forms of prevention do not attempt to end the generation of inequities in the distribution of disease and illness by focusing on the structures of power that create economic and social conditions. Those conditions are generally not under control of the individual.

Similarly, preventive medicine involves medical practices designed to avert and avoid disease, disability and death. For example, screening for hypertension and treating it before it causes disease. It emphasizes a proactive approach to patient care and focuses on the health of individuals and communities. Problems arise, however, with relying on either approach for eliminating health inequities.

A set of advantages systemically conferred on a particular person or group of people.

Public health is "concerned with the social, economic, cultural, and political conditions that shape the health of populations."[111] Per the American Public Health Association, public health promotes and protects the health of people and the communities where they live, learn, work and play. The classic de□nition, still accepted today, was developed by CEA Winslow in 1920: "The science and art of preventing disease, prolonging life, and promoting health through the organized e□orts and informed choices of society, organizations, public and private communities, and individuals."[112] Public health "is fundamentally about community and about shared values of life, health and security."[113]

The primary goal of public health is to prevent disease and promote health at the population level. As a social enterprise, public health exists simultaneously as an area of knowledge and a □eld of practice. The practice includes a variety of organized institutions and professionals, governmental and non-governmental. The non-governmental organizations can include communities and facilities run by non-pro□t organizations. In some ways public health includes an interdisciplinary range of activities since all realms of economic and social life play a role in a□ecting health outcomes, particularly health inequities.

Collection of stories or explanations that re□ect a shared interpretation of how the world works. According to the Narrative Initiative, "Narratives are often described as a collection or system of related stories that are articulated and re□ned over time to represent a central idea or belief. Unlike individual stories, narratives have no standard form or structure; they have no beginning or end. What tiles are to

people as 'abnormal'; the *political* power to withhold basic rights from people of color and marshal the full power of the state to enforce segregation and inequality; the social power to deny people of color full inclusion or membership in associational

lower wage rates, but also in excluding or segregating African Americans in access to labor markets in sectors of the economy through constricting worker rights. The consequences included exacerbating economic insecurity and stability in employment which has had negative e□ects on health outcomes.

Underlying systems and structures of social injustice that generate health inequity over time, including white supremacy, patriarchy, and class oppression. They interact with each other to produce social exclusion, marginalization and exploitation.

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school segregation, for example, social exclusion limits full participation in community and social life for particular groups of people.

Describes the correlation between socioeconomic status and health; a person of lower-socioeconomic status will generally have poorer health than an otherwise similar person of higher socio-economic status.[78]

The state of social, economic and political equality and realizing "the institutional conditions necessary for the development and exercise of individual capacities and collective communication and cooperation."[87] It is a standard concerned primarily with outcomes not process. The structure of power relations in a society determines the opportunities to achieve social justice.

Focuses on systemic barriers, derogatory attitudes, and social exclusion (intentional or inadvertent), which make it di□cult or impossible for individuals with impairments to attain their valued functionings. The social model of disability stands in contrast to the dominant medical model of disability, which is a functional analysis of the body as a machine to be □xed in order to conform with normative values.[101,102]

The social model distinguishes impairment (used to refer to the actual attributes, or lack of attributes, that a□ect a person) from disability (used to refer to the restrictions caused by society when it does not give equivalent attention and accommodation to the needs of individuals with impairments).[124] Honoring the principle of "Nothing about us, without us," the social model of disability also calls for all education promoting the health of persons with disability to be guided and informed by persons with disabilities.[125,126]

The individual-level material resources and psychosocial circumstances required for wellbeing of one's physical and mental health. These also include social risk factors, or speci□c adverse social conditions that are associated with poor health, including social isolation, food [illegible]

Assignment of assumed characteristics or attributes to the members of a given group (e.g., by ethnicity, nationality, class, or other status/identities). It occurs in a variety of historical representations or expressions that can cause trauma and racial injury by "otherwi[illegible]th disa, or other

language places an illness before the person, giving primacy of the illness (e.g., “mental illness”) over the human being.

According to Jonathan Metzl and Helena Hansen, “the trained ability to discern how a host of issues de□ned clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication “non-compliance,” trauma, psychosis) also represent the

profession in accessing care and treatment. A growing body of research continues to elucidate health inequities experienced by transgender individuals and further underscores the need for medical providers to be appropriately trained to deliver care to this population. Research has shown that transgender populations experience signi□cant health disparities such as a disproportionately higher burden of mental health illness, including increased rates of depression, anxiety and suicide.[135]

Direct translation of the Ojibwe term, Niizh manidoowag. "Two-Spirited" or "Two-Spirit" is usually used to indicate a person whose body simultaneously houses a masculine spirit and a feminine spirit. This pan-Indigenous term can also be used more abstractly, to indicate the presence of two contrasting human spirits (such as Warrior and Clan Mother), challenging the colonial gender binary. Two-Spirit People (also Two Spirit or Twospirit), an English term that emerged in 1990 out of the third annual inter-tribal Native American/First Nations gay/lesbian American conference in Winnipeg, describes Indigenous North Americans who ful□ll mixed gender roles in their respective community. The mixed gender roles encompassed by the term, historically included wearing the clothing and performing work associated with both men and women. It's important to know that the traditional term for Two-Spirit identity varies ng (en-US)/MCT nBT10.5 0 00 (om235.12(en-US)/MCID 3641 BDC BTp (onf)13 (er)10 (encT10.5 0

"White supremacy is not only…associated with…extreme political movements [but] is seen to relate to the operation of forces that saturate the everyday, mundane actions and policies that shape the world in the interests of white people."[141] White supremacy, constantly adapting to legal and cultural changes, persists in part by the way many whites ignore their whiteness to the point of invisibility, their role in a racial hierarchy, and the privilege it gives them. A myth of innocence, an assumption of objectivity and other rationalizing devices, supports an unwillingness to recognize or reckon with racial injustice. It furthers a refusal to recognize their complicity in a rming and normalizing the structure of racist domination. Social codes, "othering" people who are not white, and the threat of violence or its anticipation play a role in supporting white supremacy.

It is important to di erentiate "white" (a category of racial classi cation with no scienti c basis) and "whiteness" (re ecting the power and privileges that people who are de ned as white receive).[142] Whiteness, in this way, is both cultural and socioeconomic power and privilege.[143] Whiteness, according to sociologist Ruth Frankenberg, is "dominant cultural space with enormous political signi cance, with the purpose to keep others on the margin. … white people are not required to explain to others how 'white' culture works, because 'white' culture is the dominant culture that sets the norms. Everybody else is then compared to that norm."[144] It is a complex and debated term, full of paradox, as exempli ed in Jonathan Metzl's *Dying of Whiteness*.[145]

We recognize that health equity work is extensive and collaborative—that we follow in the footsteps of countless individuals and groups who have dedicated their lives to the issue of equity for decades, generations even. We value your e orts and conviction. We look forward to our continued collaboration.

Acknowledgments

This guide is not intended to be a definitive and all-encompassing instruction manual. Instead, it was written (with humility) to stimulate heightened awareness and dialogue. We offer this guide as a tool, knowing that efforts to nurture change in contentious spaces requires courage and commitment. Undermining systemic oppression and the dominant narratives that sustain them will not happen by chance. Reclaiming and promoting a social justice narrative will require intentional and collective action. This guide is a first step.

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