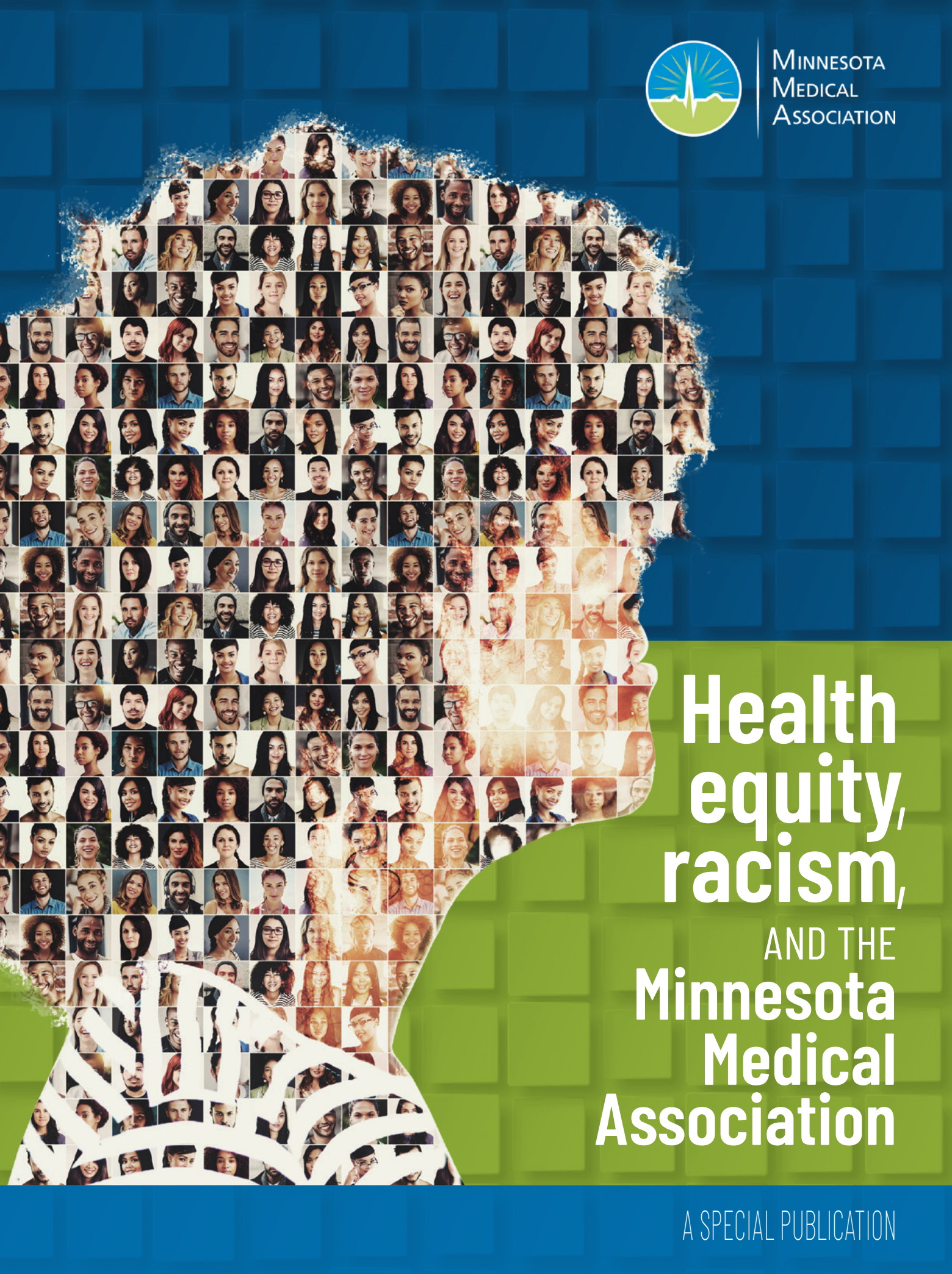
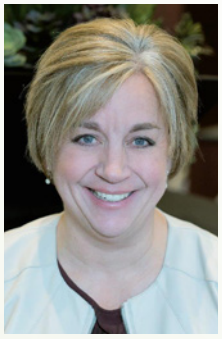


Minnesota Medical Association

Health equity, racism, AND THE Minnesota Medical Association

A SPECIAL PUBLICATION


Edwin Bogonko, MD, MBA


Janet Silversmith

LETTER FROM MMA LEADERSHIP

On behalf of the MMA, we are pleased to share this special report with you—our valuable members and partners. The serious and persistent racial and ethnic inequities experienced by historically marginalized Minnesotans have been clearly articulated and documented.

There is also ample evidence of the role that racism, all forms of bias, and a variety of social factors—from polluted air to lack of affordable housing—play in influencing healthcare access and health outcomes. But acknowledging the problem means precisely little if such acknowledgement is not followed by action. Over the course of its history, the MMA, for too long and too often, failed to act. To so many physicians of color denied career visibility and advancement, confined to practice environments intended to marginalize and disenfranchise, as well as those whose leadership trajectory was systemically blunted—we, the MMA, sincerely apologize.

Since 2018, MMA leadership has made improved health equity an explicit outcome in our strategic plan. To help realize that goal, we are working to leverage the MMA's skills and expertise in advocacy, education, and leadership. The focus of our health equity work has been honed by the continuous input of MMA members, young and old. This special report summarizes the current focus of our work and the progress to date; it reflects our commitment to hold ourselves accountable for our actions. This report also includes a brief look at the organization's historical record with respect to racism and discrimination, including its disappointing lack of leadership, not only during the MMA's earliest years but well into the 20th century.

There is much to do, but we are excited about our direction, encouraged by our progress, and grateful for the support of our members and partners. The MMA is uniquely positioned to bring all Minnesota physicians together to make Minnesota the healthiest state and the best place to practice medicine just and equitable, free from distrust or disparities, without any racial considerations. That is our promise!

Please share your comments and ideas with us at mma@mnmed.org.

Thank you for your support in advancing this work with us.

EDWIN N. BOGONKO, MD, MBA
CHAIR, MMA BOARD OF TRUSTEES

JANET L. SILVERSMITH
CHIEF EXECUTIVE OFFICER

BACKGROUND

Significant racial and ethnic disparities in healthcare access and health outcomes exist and are well documented in Minnesota. The MMA's mission to "make Minnesota the healthiest state and best place to practice" clearly compels the organization to take action on these disparities.

Documented evidence of MMA's interest in addressing health disparities can be traced back to the early 1990s, when the MMA House of Delegates called on the MMA to appoint a standing committee "on minority problems, to include Native American, Hispanic, Black, and other minority physicians." In response, in 1992, the MMA convened the first meeting of the new Minority Affairs Committee. This committee led efforts to provide physicians with training in cultural competency, to support health plan coverage for interpreter services, to encourage careers in medicine among students of color, and established an MMA award to recognize physicians for exceptional service to minority communities.

The Minority Affairs Committee was modified and renamed in 2015 as the Health Disparities Work Group (later renamed the Health Equity Advisory Committee). The new group reflected a renewed commitment by the MMA to actively address health disparities. This was largely in response to the newly-published report and data from the Minnesota Department of Health, led by then-Commissioner Edward Ehlinger, MD.

In 2018, the MMA embarked on a new strategic planning effort and, as part of that, added "improved health equity" as an explicit outcome, an acknowledgment that our most vulnerable communities continue to face health disparities and that collective action within the medical community is needed to achieve health equity in Minnesota. The three areas defined by the MMA board as priority areas of focus, or measures of progress toward the goal of health equity, are: to diversify the Minnesota physician workforce, to address the social drivers of health, and to work to reduce structural racism and implicit bias in healthcare and the culture of medicine. Background and MMA efforts on these three priorities are detailed in this special publication.

The COVID-19 pandemic disrupted much of MMA's planned work on health equity in 2020. In May 2020, George Floyd was murdered by police in Minneapolis and the city and the nation exploded in grief, anger, and sometimes violence. Floyd's death further propelled MMA leaders and members to actively address issues of racism and inequity in healthcare and in our society.

On June 5, 2020, the MMA called on Minnesota's medical community to help heal and lead. Through *Insights*, its leadership communication to members, MMA asked its members to come together to combat the root cause of health disparities—institutional, systemic, and structural racism—dismantle the legacies and policies that enable racism and bias, and demand societal change. The MMA then convened its Policy Council, Public Health Committee, and Health Equity Advisory Group, and invited physician leaders from across the state to meet collectively to refocus and accelerate the work of the organization.

We determined that we also would need to look internally, to examine the history of the MMA and its record on racism and disparities. MMA commissioned Mary Kate Wolken, a doctoral student in the History of Science, Technology, and Medicine program at the University of Minnesota, to research MMA records and analyze those findings. The results were sobering but not necessarily surprising. The MMA was not, in its early days, a leader in challenging racist practices, comments, and thinking. It reflected the racist attitudes of White culture at the time, with all the "jokes," labels, indifference, and division of the world into those who count (White people) and those who don't. The MMA was no worse, perhaps, but certainly no better than the dominant society at the time. Our history does not define who we are today, but it does help us understand how important it is to take on this work.

OUR MOST VULNERABLE COMMUNITIES CONTINUE TO FACE HEALTH DISPARITIES. COLLECTIVE ACTION WITHIN THE MEDICAL COMMUNITY IS NEEDED TO ACHIEVE HEALTH EQUITY IN MINNESOTA.

DIVERSIFYING THE PHYSICIAN WORKFORCE

"Studies show that racial, ethnic, and gender diversity among health professionals promotes better access to healthcare, improves healthcare quality for underserved populations, and better meets the healthcare needs of our increasingly diverse population."

—JESSE M. EHRENFELD, MD, MPH, AMA PRESIDENT-ELECT IN A 2021 STATEMENT

The Minnesota physician workforce—like that in most states—doesn't accurately reflect the racial and ethnic demographics of the state. Minnesota's population is 83% White; the physician workforce is 76% White. For some racial/ethnic groups, however, the disparity is great: Minnesota's population is 7.4% Black but the physician workforce is only 2.6% Black. Indigenous people make up 1.4% of the state's population, but only .2% of the physician workforce [Minnesota Board of Medical Practice and U.S. Census 2021 estimates].

Concerted efforts to diversify the physician workforce are not new. Yet, according to a recent analysis (https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2749233), Black, Hispanic/Latino, and Indigenous students remain underrepresented among medical school enrollees compared with the U.S. population and without significant change since 2009, the year the Liaison Committee on Medical Education (LCME) first required medical schools to work to improve the diversity of medical school enrollees.

The MMA doesn't capture race and ethnicity data in its membership records, so it is not possible to determine if the MMA is more or less representative of Minnesota physician diversity.

WHY IT MATTERS

- Patients are more likely to be satisfied with their medical care if they see a physician of the same race or ethnicity; several studies suggest that they are more comfortable and more likely to trust a physician of their same race or ethnicity—and so are more inclined to follow medical advice [Takeshita, Wang, Loren, et al, *JAMA Network Open* November 9, 2020]. Physicians who share race or ethnicity with patients may be able to communicate more effectively than those who don't because of their shared experiences and background.
- Racially and ethnically marginalized physicians—in particular, Black physicians, are more likely to work in underserved communities [Xierali and Nivet, *Journal of Health Care for the Poor and Underserved*, 2018].

- All physicians benefit when they work with others who have different experiences and perspectives, which may arise in part from different racial and ethnic backgrounds. Greater diversity among physicians creates the potential for sharing and enhancing ideas.
- The relative lack of Black and Indigenous physicians in Minnesota may make the state less inviting to potential medical students, residents, and physicians of color, thus maintaining and even increasing lack of diversity.
- The MMA can more effectively understand and respond to concerns of Black, Indigenous, and Hispanic/Latino physicians (and so, patients) if its membership includes those physicians as active participants in developing policy, events, and advocacy.

BLACK, HISPANIC/LATINO, AND INDIGENOUS STUDENTS REMAIN UNDERREPRESENTED AMONG MEDICAL SCHOOL ENROLLEES COMPARED WITH THE U.S. POPULATION AND WITHOUT SIGNIFICANT CHANGE SINCE 2009.

MMA EFFORTS

Barriers to Workforce Diversification in Physician Education, Training, and Licensure Task Force

In December 2020, the MMA Board of Trustees commissioned a task force to examine the barriers in medical education, residency training, and the licensure process that affect the supply and distribution of Black, Indigenous, and other underrepresented people in medicine. A 37-member task force, led by co-chairs, Kacey Justesen, MD, and Verna Thornton, MD, which included pre-med students, medical students, residents, medical school leadership, residency program leadership, and community physicians, met over the course of 15 months. The task force identified three primary barriers to physician workforce diversification: lack of exposure and preparation options, financial barriers to medical training, and historic bias and systemic racism in medicine.

At its September 19, 2022 meeting, the MMA Board adopted the task force's 14 recommendations to mitigate the identified barriers. As this publication goes to press, MMA staff are working on implementation plans.

MMA Physician Mentorship Program

The MMA pairs pre-med students, medical students, and residents/fellows with medical students, practicing physicians, residents/fellows, and retired physicians Although the program is open to all physicians in training, it has actively partnered with medical students from Northwestern Health Sciences University and the Minority Association of Pre-Medical Students (MAPS) at the University of Minnesota, many of whom come from racial and ethnic groups underrepresented in medicine. Over the past two years, the MMA has made more than 70 mentorship matches.

Educational activities

The MMA screened the documentary "Black Men in White Coats" in April 2021. The MMA provided free tickets to more than 400 Minnesota physicians and physicians in training to view the documentary and then hosted a panel discussion with a large and diverse audience. Dale Okorodudu, MD, and two other physicians profiled in the film took part in the discussion.

ALLEVIATE SOCIAL DRIVERS OF HEALTH

"Decades of study on the social determinants of health show that the policies and processes that shape the daily circumstances of our lives are what really create health. Our individual behaviors are overshadowed by a much larger set of economic and social forces put into action by policy decisions at every level of government."

—MINNESOTA STATEWIDE HEALTH ASSESSMENT ISSUED IN 2017 AND UPDATED IN 2019

Physicians generally see their patients only in the clinic or the hospital setting (or, today, on a computer, smartphone, or tablet screen). They diagnose and treat patients while seldom knowing the environment in which those patients live, work, and play.

And yet, those conditions outside the exam room impact not only the reason someone may seek medical help but also whether and how treatment will be effective.

The Office of Disease Prevention and Health Promotion of the U.S. Department of Health and Human Services defines five priority areas of social determinants, or drivers, of health in its Healthy People 2030 initiative. (MMA chooses to call these social drivers of health, rather than seeing them as "determinants" that can't be changed.) The five priority areas are:

- Economic stability
- Education access and quality
- Healthcare access and quality
- Neighborhood and built environment
- Social and community context

Social drivers of health contribute to health disparities and inequities. Poorer communities, many of them home to people of color, are less likely to have grocery stores with healthful foods easily available, more likely to be in areas with air and water pollution, and may have limited transportation, unsafe housing, and a greater likelihood of violence. All of these, and more (racial discrimination, underfunded schools, lack of language and literacy skills) increase the likelihood of health problems.

Most physicians and healthcare systems understand that to be truly effective at working with and helping a patient, they need to assess the social drivers of health for that person, but long-term improvement in the social drivers of health must be addressed at a community, state, national, and global level.

WHY IT MATTERS

According to an April 2022 report from the Office of Health Policy of the U.S. Department of Health and Human Services, studies estimate that clinical care impacts only about 20% of health outcomes, while social drivers of health such as poverty, unemployment or low-wage employment, food and nutrition, education, and physical environment affect as much as 50% of health outcomes.

Numerous studies have consistently found that food insecurity—when households don't have adequate food because of limited resources—is associated with poor health outcomes, from asthma in children to limitations in daily activities for seniors [Gundersen and Ziliak, "Food Insecurity and Health Outcomes," *Health Affairs* November 2015]. In 2020, 13.8 million or 10.5% of U.S. households, had low or very low food security; 21.7% of Black households, 17.2% of Hispanic/Latino households, and 7.1% of White households experienced food insecurity [USDA Economic Research Service].

Research has shown that food insecurity for children is associated with increased risks for some birth defects, anemia, cognitive problems, and aggression and anxiety. It is also associated with poorer general health and a higher likelihood of being hospitalized.

Minnesota had nearly 8,000 people experiencing homelessness on any given day, as of January 2020. Public school data reported to the U.S. Department of Education for the 2018–2019 school year (before the pandemic) estimated that more than 17,000 public school students had experienced homelessness during that year. The National Health Care for the Homeless Council estimates that people who are homeless have higher rates of illness and die, on average, 12 years sooner than the general U.S. population. Homelessness is the extreme part of the spectrum, however. People may live in housing that is not safe from physical hazards or that has poor-quality housing conditions or that is in unsafe neighborhoods. According to the Minnesota Department of Health, about 40% of diagnosed asthma among children may be attributable to exposure that they encounter where they live.

Environmental pollutants can increase the risks for respiratory diseases, heart disease, and some types of cancer. Air pollution,

a lack of water or unclean water, noise, hazardous chemicals, and a changing climate impact the health of communities and individuals. More than 12 million people around the world die each year because they live or work in unhealthy environments [*Healthy People 2030*, Office of Disease Prevention and Health Promotion].

MMA EFFORTS

The origin of the MMA, in 1853, is largely a testament to an individual physician's limits and the potential of physicians, collectively, to improve the health of the public.

Historically, much of the MMA's work to address social drivers of health has focused on advocacy with respect to personal behaviors and environmental factors, such as seat belt and helmet laws, alcohol excise taxes, and smoke-free workplace and restaurant laws. MMA advocacy also has supported state and federal policies to provide health insurance coverage for all Minnesotans. In 2020, input from MMA members convinced the Board to expand its advocacy reach to additional factors, namely safe and stable housing and the health effects/trauma associated with police interactions.

The MMA Equity in Access & Quality Committee (EAQ) has identified patient screening for social drivers of health and subsequent referrals to community resources as a key topic of interest. The MMA is coordinating its efforts with that of Stratis Health and MN Community Measurement, which are engaged in related efforts to create community models and processes for data collection.

The EAQ Committee also has as part of its charge examining and addressing the role of racist practices, policies, and structures in undermining access to delivery of high-quality care. The Public Health Committee addresses issues related to public and population health, including obesity, diet and exercise, and substance abuse—and also community issues such as crime and environmental and occupational health.

In May 2022, the MMA Policy Council formed an Illicit Drug Harm Reduction and Decriminalization Work Group (IDWG). As part of their work to recommend new MMA policy, the 25 members of the IDWG are scrutinizing the evidence base of drug possession penalties as a deterrent for drug use. The IDWG has affirmed that criminal penalties for simple possession yield numerous harms to population health— especially among communities of color—through arrests, convictions, and incarcerations.

MOST PHYSICIANS AND HEALTHCARE SYSTEMS UNDERSTAND THAT TO BE TRULY EFFECTIVE AT WORKING WITH AND HELPING A PATIENT, THEY NEED TO ASSESS THE SOCIAL DRIVERS OF HEALTH FOR THAT PERSON, BUT LONG-TERM IMPROVEMENT IN THE SOCIAL DRIVERS OF HEALTH MUST BE ADDRESSED AT A COMMUNITY, STATE, NATIONAL, AND GLOBAL LEVEL.

ADDRESS STRUCTURAL RACISM AND IMPLICIT BIAS IN HEALTHCARE

"What we know is this: racism is a serious public health threat that directly affects the well-being of millions of Americans. As a result, it affects the health of our entire nation."

—RACHEL WALENSKY, MD, MPH, DIRECTOR, CENTERS FOR DISEASE CONTROL AND PREVENTION

As we've listened to physicians talk about their concerns, one dominant theme is the desire for the culture of medicine to become more explicitly anti-racist. That means not only the culture of physician practices and systems, but also the culture of organized medicine within the MMA.

Although we think that horrors like the Tuskegee experiment simply wouldn't happen today in the United States, we are often woefully ignorant of race-based disparities in healthcare, including in our own clinics and healthcare systems. Consciously or unconsciously, physicians—like most people, of all races and ethnic backgrounds—assume or assign various qualities to those of a certain ethnicity, racial background, economic status, education level, or other identifier.

We can correct ourselves—and each other—when an overtly racist or discriminatory comment or act occurs. And we should make those corrections. But racism is baked into healthcare and medicine in the same way it is baked into our society overall.

Structural racism is pervasive in our society—so pervasive that we often don't recognize it. It is the policies, practices, and norms that serve to maintain White supremacy. Because they surround us, we often see them as "just the way things are." It is only within the last couple of decades, for example, that questions have arisen about race-based medicine. When we look at the social drivers of health, including inadequate housing, unsafe water and polluted air, inferior education, lack of decent employment, etc., we are seeing the evidence of structural racism over not just decades, but centuries. Police brutality and police violence, very much in discussion today, are products of structural racism.

A 2003 report from the Institute of Medicine, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," concluded that racial and ethnic minorities received worse care than non-minorities—even when insurance, family income, and other social drivers of health were controlled—and that both explicit and implicit bias likely were responsible.

To take on structural racism and implicit bias, we first have to recognize them.

WHY IT MATTERS

Racism is a social driver of health. The physiological impact of racism alone can adversely impact the health of individuals and communities. But the results of structural racism have too often left racially/ethnically marginalized individuals living with inadequate housing, employment, education, and physical safety.

People who see the medical community as being not of them, with too few physicians or other healthcare providers who look like them or who seem to have similar experiences and world views, are people who will avoid seeking medical care—and are likely to distrust instructions they receive if and when they do have to obtain medical treatment.

Structural racism prevents and deters many racially/ethnically marginalized people from pursuing medical careers, which in turn separates the medical community from many of the patients it needs to serve. It's a vicious cycle.

Research and clinical protocols that fail to take into account race or ethnicity or, conversely, that treat race and ethnicity as a proxy for genetics or heredity, are limited in both applicability and science.

Physicians of good conscience want to recognize any implicit biases they hold—and these kind of biases are not restricted to White physicians; all of us have biases that impact the way we in-

RACISM IS BAKED INTO HEALTHCARE AND MEDICINE IN THE SAME WAY IT IS BAKED INTO OUR SOCIETY OVERALL.

teract with others—so that they can better serve their patients and their communities.

MMA EFFORTS

Advocacy

In November 2020, the MMA delegation to the AMA successfully introduced and created new AMA policy that calls on the AMA to work to end the use of race as a proxy for biology, genetics, or heredity when treating patients, yet recognizes that race does have an influence on health outcomes because of racism and systemic oppression.

In regards to racism and policing, the MMA has called on policymakers and our healthcare community to recognize the detrimental effects that racism and violence have on the mental, physical, and economic health of Black, Indigenous, and other marginalized people. As part of this effort, the MMA will:

- Advocate for the creation of an ICD-10 code for experiencing racism, a code that will provide physicians with the tools necessary to address racism within the clinical encounter, and capture the data needed to provide more effective patient care.
- Advocate for a change to the standard death certificate to include a check box that would categorize deaths in criminal justice custody and would create a new statistical grouping with explanations of the range of causes within the spectrum of criminal justice custody.
- Advocate for research to be conducted that examines the public health consequences of negative police interactions.
- Advocate for law enforcement to be trained on implicit bias and structural racism.
- Develop a toolkit/set of best practices for practicing physicians to assist them in having conversations with their patients about racism and the trauma that has resulted from negative police interactions.
- Urge medical schools and residency programs in Minnesota to include education in their curricula about implicit bias and structural racism; how to identify and confront racism and police brutality; and past incidents and examples of the medical profession (mis)treating Black, Indigenous, and other people of color, and how this has led to a mistrust of the medical profession.
- Urge clinics, hospitals, and other healthcare systems and providers to review and reconsider their policies and their relationships with law enforcement that may increase harm to patients and our communities.

Educational and convening activities

Thanks to generous support from UCare, the MMA is working to change the culture of bias and racism in medicine. In August 2021, the MMA convened the Minnesota Health Equity Community of Practice. Through this network, health equity champions and leaders from physician practices and health systems meet to share resources, experiences, and challenges. In addition to facilitating connection, the MMA provides Community of Practice members with access to local and national experts. The MMA was recently recognized nationally for this program.

A free Implicit Bias in Healthcare Workshop developed by the MMA is available by request so that any healthcare organization or group can have a private workshop. Physicians may claim up to 2 AMA PRA Category 1 Credit(s) for completing this workshop. A free, three-part Implicit Bias Learning Series developed by MMA is available online. It is eligible for AMA PRA Category 1 Credit(s).

The MMA continues to provide additional education on pertinent and timely health equity issues, including hosting a "Mitigating Microaggressions Toward Physicians of Color" session at the 2021 Annual Conference, along with several health equity-focused Physician Forums on "Housing is Health," "Elevating the Voices of Black Physicians," "Eliminating Race-based Medicine," and "Examining Maternal Mortality through a Health Equity Lens." All programs are archived and available online.

Internal culture

Importantly, the MMA has heeded the call from members (and non-members) to assess its own culture. To date, all staff have participated in training on microaggressions and a half-day anti-racism program. All MMA Board members, committee chairs, and other leaders also participated in the half-day anti-racism program.

The MMA also has incorporated a Health Equity Time Out into its policy-making process. Before taking action, a Health Equity Time Out is called to consider potential health equity implications. Like its surgical namesake, the Health Equity Time Out is designed to create a safe space for any committee member, Board member, or staff person to raise health equity considerations before decisions are made.

The MMA also examined its historical record, namely proceedings of the House of Delegates and content in *Minnesota Medicine*. This work was completed with the help of external, academic expertise. A high-level summary of the results of that examination are included in this publication.

THE MMA'S RECORD ON RACE

"Acts of omission and commission reflected the social mores and racial segregation that existed during those times throughout much of the United States. But that context does not excuse them. The medical profession, which is based on a boundless respect for human life, had an obligation to lead society away from disrespect of so many lives."

RONALD M. DAVIS, MD, AMA PAST-PRESIDENT, 2008, ON AMA'S PAST DISCRIMINATORY PRACTICES

The MMA has existed for nearly 170 years and its record of dealing with race—of both physicians and patients—has been complicit and, often, shameful.

The organization was founded in 1853, but effectively paused during the Civil War, then was revived in 1869 after the war. The MMA began as a state society of the American Medical Association and its early history is closely linked to the national organization and its policies and practices.

The AMA, founded in 1847, was conceived as a "social and scientific fraternity." Membership offered physicians a way to meet colleagues, share research and expertise, protect themselves from charges of fraud, and cultivate business relationships. Exclusion, then, meant missing these opportunities to be part of the medical establishment in the United States.

During the Reconstruction era, two attempts to add Black physicians to AMA meetings led to AMA rules that transferred responsibility for determining eligibility of AMA delegates to the states—effectively excluding most Black physicians because most Southern medical societies did not allow Black members [Baker, Olakanmi *et al*, "African American Physicians and Organized Medicine, 1846–1968: Origins of a Racial Divide." *JAMA*, 2008].

The MMA didn't explicitly bar Black physicians and its 1869 bylaws have no restrictions on membership based on race; however, it deferred membership decisions to county societies, rather than at the state level. Black physicians were rare to nonexistent in the organization; the first Black physician licensed to practice in Minnesota, Robert S. Brown, MD, was not a member of MMA in the late 1800s, despite his activity in other community organizations.

Racist and discriminatory language and "humor" were common in the early 20th century (and are still too common today) and MMA was part of this culture. MMA House of Delgates meeting minutes show numerous "jokes" about Blacks, Jews, and immigrant groups, including the Irish. In 1927, a session opened with a racist joke at the expense of the Black staff serving meals to the delegates.

The racism documented in MMA records was more than casual humor, it also was reflected in the way the MMA reported on medical treatment. In 1921, an editorial in *Minnesota Medicine* declared that concern about positive syphilis tests didn't have the same significance for Blacks as for Whites. In 1930, an article on tuberculosis warned physicians to be careful about the Black people and Indigenous people they might hire as domestic servants—in order to protect their own health.

In the 1930s and 1940s, Minneapolis was considered one of the most anti-Semitic communities in the United States. No explicit patterns of anti-Semitism were found in MMA records, but there were occasional instances of the MMA leaning into stereotypical descriptions of Jewish patients. The 1951opening of Mt. Sinai Hospital was a significant moment in the Twin Cities community, giving Jewish doctors access to hospital privileges that had been denied elsewhere. Curiously, there is little to no mention, however, of Mt. Sinai in MMA records reviewed for this analysis.

Some MMA records reveal deeply paternalistic attitudes towards Indigenous populations and communities in Minnesota. In the early 1950s, an era of intense opposition to any form of compulsory insurance or government "control" of medicine, MMA physicians called for federally-funded programs to combat tuberculosis in Native communities.

By the early 1970s, records reveal that the MMA was increasingly aware of and sensitive to racial disparities and the obstacles to healthcare for traditionally marginalized communities and began efforts to address them, efforts that continue and shape MMA work today.

KEY EVENT TIMELINE

1837 James McCune Smith is first Black American to graduate with a medical degree (University of Glasgow)

1846-47 American Medical Association is formed

1847 David Jones Peck is first Black man to graduate from a U.S. medical school

1853 Minnesota Medical Society (precursor to MMA) is formed

1854 John Van Surly DeGrasse is first Black man admitted as a member of a U.S. medical society (Massachusetts)

1858 Minnesota is granted statehood

1862 Freedmen's Hospital is built in Washington DC

1863 President Lincoln signs the Emancipation Proclamation

1864 Rebecca Lee Crumpler is first Black woman to graduate from a U.S. medical school

1865 13th Amendment to the US Constitution, abolishing slavery, is ratified

1868 Howard University Medical School opens

1870 Integrated National Medical Society of the District of Columbia is formed, in response to denial of membership to three Black physicians by the Medical Society of the District of Columbia

National Medical Society of DC members are excluded from the annual AMA meeting

1872 AMA reaffirms refusal to admit Freedmen's Hospital, Howard University, and National Medical Society (all Black organizations) to membership.

Minnesota State Medical Society initiates legislation that creates a state board of health

1873 AMA gives power of recognition of official local societies to states, avoiding national responsibility

1876 AMA seats first female delegate/member, Sarah Hackett Stevenson of Illinois, but racial divide remains

1883 First issue of the *Journal of the American Medical Association* is published

1887 Minnesota State Medical Society successfully lobbies for state law requiring physicians to be examined by medical examiners board

1892 *The Medical and Surgical Observer*, the first Black medical journal, is published

1895 The National Medical Association is founded by Black physicians following many failed attempts to integrate all-White medical societies

1896 Robert S. Brown becomes the first Black physician licensed to practice in Minnesota

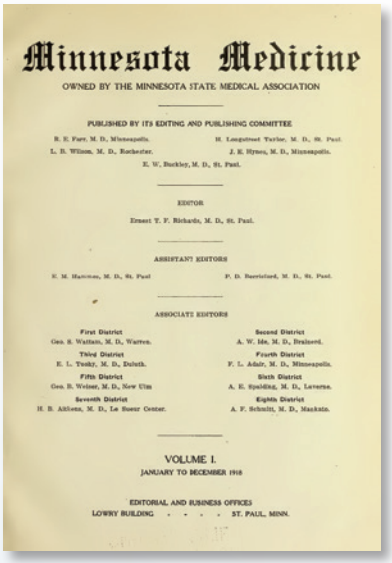
DR. R. S. BROWN, Physician and Surgeon. Office, rooms 405-6 Reeve building, 403 Nicollet avenue; telephone 548. Residence, 2839 Portland avenue; telephone 317—L south. Office hours: 9:30 to 12:30; 2 to 4:30; 7 to 8:30. Sundays, 9:30 to 11; 12:30 to 2.

1903 The Minnesota State Medical Society is renamed the Minnesota Medical Association

1906 AMA publishes the first volume of the *American Medical Directory*. Black physicians have "col" after their names to indicate that they are "colored"

1910 *Flexner Report*, requested by AMA in 1908, is published with wide-ranging repercussions, including the closure of five of seven Black medical schools and a significant number of women's medical schools

1918 MMA publishes the first issue of *Minnesota Medicine*



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EDITOR

ASSISTANT EDITORS

ASSOCIATE EDITORS

VOLUME I.
JANUARY TO DECEMBER 1918

EDITORIAL AND BUSINESS OFFICES
LOWRY BUILDING . . . . ST. PAUL, MINN.

Influenza pandemic begins

1920 The Black Hospital Movement begins

1924 Indigenous Americans granted U.S. citizenship

Indigenous Americans with U.S. President Calvin Coolidge in 1924

1932 Tuskegee syphilis study begins

1934 AMA adopts position against compulsory health insurance

1936 *JAMA* publishes the first academic article on the Tuskegee syphilis study

1938 Official National Medical Association representatives are recognized by the AMA for the first time to discuss issues of race discrimination in medicine

Princeton survey shows that the majority of Americans don't believe the Jewish population deserves equal rights

1939 AMA discontinues listing Black physicians as "colored" in its *American Medical Directory*

First of more than a dozen separate occasions, up to 1968, when the AMA reiterated its discouragement of racial discrimination by constituent societies but invoked its "local autonomy" principle to vote against motions that would expressly prohibit that discrimination


A man receiving treatment in the Tuskegee Syphilis Study

MMA delegate to the AMA reports "there is no antipathy whatsoever so far as the AMA is concerned against Negro physicians"

1945 Black and white physicians protest racially exclusive policies of the American College of Surgeons and other specialty boards

26 of the 78 accredited medical schools are closed to Black students

1946 Hill Burton Act signed into law; it perpetuated segregation of medical facilities through "separate but equal" practice of distributing hospital funding for nearly two decades

Minneapolis described as "the capital of anti-Semitism in the United States" by journalist Carey McWilliams in *Common Ground*

1949 Association of American Medical Colleges fails to publicly oppose race discrimination in medical schools and unequal opportunities in premedical education, arguing it lacks the jurisdiction to do so

1950 AMA House of Delegates passes a resolution urging component societies to study race discrimination "... taking such steps as they may elect to eliminate such restrictive provisions"

AMA eliminates designations of race, creed, and color from its "Situations Wanted" ads published in *JAMA*

1951 Mount Sinai Hospital opens in Minneapolis in response to discrimination against Jewish physicians by other hospitals and to improve hospital bed supply

1955 Veterans Administration orders all of its facilities to desegregate

1960 Eight Black physicians are arrested in Georgia after attempting to be seated at a local medical society meeting in the "whites-only" dining room of the Biltmore Hotel

1963 AMA opposes pending Medicare legislation; National Medical Association supports it

1964 Congress passes Civil Rights Act of 1964

AMA opposes requirements for physicians to formally denounce racial discriminatory practices as a condition of receiving federal funds


Signing of the Civil Rights Act

1966 AMA House of Delegates declares that it will receive appeals from those who allege they, because of color, creed, race, religion, or ethnic origin, have been denied membership in a component and/or constituent society

1969 *Minnesota Medicine* ends practice of referring to "colored" people

Minnesota Chapter of the National Medical Association is formed with Curtis Davis, MD, as its first president. It later is renamed the Minnesota Association of African American Physicians

1976 *Minnesota Medicine* stops using the term "negro"

US. Government Accountability Office investigation reveals widespread sterilization of Native American women, including in Minnesota

1992 MMA Committee on Minority Affairs is formed

1995 Lonnie Bristow, MD, becomes the first Black president of the AMA


Lonnie Bristow, MD

2003 Institute of Medicine issues report, "Unequal Treatment," on racial and ethnic disparities in healthcare

2004 J. Michael Gonzalez-Campoy, MD, PhD, is MMA's first Hispanic/Latino president


J. Michael Gonzalez-Campoy, MD, PhD

2013 Minnesota Department of Health creates Center for Health Equity

2014 Minnesota Department of Health publishes report, "Advancing Health Equity in Minnesota," for the Legislature, catalyzing renewed attention and action on disparities in Minnesota

2015 MMA convenes Health Disparities Work Group, later renamed the Health Equity Advisory Committee

2016 Dionne Hart, MD, becomes first Black female member of MMA Board of Trustees


Dionne Hart, MD

2018 MMA and partners convince Gov. Mark Dayton to declare January 2018 Health Equity Month to "raise understanding and awareness of persistent disparities in health, well-being and socioeconomic status among Minnesota's marginalized communities, and to encourage systematic changes so that every person has equal opportunity to attain the highest possible level of health"

MMA makes "improved health equity" an explicit outcome in its strategic plan

2019 Patrice Harris, MD, becomes AMA's first Black woman president


Patrice Harris, MD

AMA establishers Center for Health Equity

2020 Edwin Bogonko, MD, is elected MMA's Board Chair, the first person of color to be Board Chair


Edwin Bogonko, MD, MBA

MMA successfully advances policy directing AMA to work to eliminate race as a proxy for ancestry, genetics, and biology in medical education, research, and clinical practice

George Floyd, a Black man, is killed by Minneapolis police officers. There are protests and calls for change across the country

MMA convenes a Joint Health Equity Meeting of its Policy Council, Public Health Committee, Health Equity Advisory Group, and other physician leaders from across the state to accelerate MMA action on health equity and structural racism

MMA commissions task force to examine barriers to physician workforce diversification

MMA receives funding from UCare to develop implicit bias and anti-racism education and resources

2021 *JAMA* promotes podcast involving deputy editor with a tweet stating, "No physician is racist, so how can there be structural racism in health care?" and experiences swift backlash; both deputy editor and editor later resign

MMA launches MN Health Equity Community of Practice to support health equity initiatives and best practices across medical groups and health systems

2022 MMA's Health Equity Time Out and Community of Practice receive recognition awards from American Association of Medical Society Executives

MMA publishes health equity progress report and historical review

FREE Implicit Bias Training for Your Organization

The MMA is now offering **private workshops** for healthcare organizations to make implicit bias training available to their physicians and healthcare providers.

In the 2-hour interactive workshop, participants will examine implicit bias in healthcare settings, understand how it contributes to health disparities, and learn practical strategies for mitigating the effects.

Both in-person and virtual options are available.

2 AMA PRA Category 1 Credit(s)™ are available.

To book this workshop for your organization, please contact:

Haley Brickner, Health Equity Coordinator
hbrickner@mnmed.org | 612-355-9344

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