ADVANCING HEALTH EQUITY:

A GUIDE TO LANGUAGE, NARRATIVE AND CONCEPTS

AMA AMERICAN MEDICAL ASSOCIATION

AAMC CENTER FOR HEALTH JUSTICE

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.

Land and Labor Acknowledgement

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 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. Collectively, we have an opportunity and obligation to overcome these fissures and create spaces for understanding and healing.

Introduction

The field 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 and evidence in a particular area, one of the first tasks is to find trusted resources, so that one can learn more. In that spirit, teams from the American Medical Association and the Association of American Medical Colleges (AAMC) Center for Health Justice came together to produce this document, "Advancing Health Equity: A Guide to Language, Narrative and Concepts," providing physicians, health care workers and others a valuable foundational toolkit for health equity.

To be sure, this is not about personal intentions. The majority of us have the right intentions in place; we wish to see improved health outcomes for all. Yet the evidence—the science—shows that even despite great intentions, some decisions made at the practice and institution level, and by individuals themselves, are not meeting our intended desired impact to ensure the full potential for optimal health for our patients. Most alarmingly, there are signs some of our systems continue to exert harm, creating and perpetuating inequities.

By health inequities, we mean gaps that are "unjust, avoidable, unnecessary and unfair."[1,2] They are neither natural nor inevitable. Rather, they are produced and sustained by deeply entrenched social systems that intentionally and unintentionally prevent people from reaching their full potential. Inequities cannot be understood or adequately addressed if we focus only on individuals, their behavior or their biology.[3,4] We have the opportunity—and the obligation—to do better, and to achieve more equitable outcomes. We believe that a critical component of that effort involves a deep analysis of the language, narrative and concepts that we use in our work.

We share this document with humility. We recognize that language evolves, and we are mindful that context always matters. This guide is not and cannot be a check list of correct answers. Instead, we hope that this guide will stimulate critical thinking about language, narrative and concepts—helping readers to identify harmful phrasing in their own work and providing alternatives that move us toward racial justice and health equity.

In Part 1, we offer a guidance on language for promoting health equity, contrasting traditional/outdated terms with equity-focused alternatives. In Part 2, we explore how narratives (the power behind words) matter. Lastly, in Part 3, we provide a glossary of key terms, defining key concepts, and whenever possible acknowledging debates over definitions and usage.
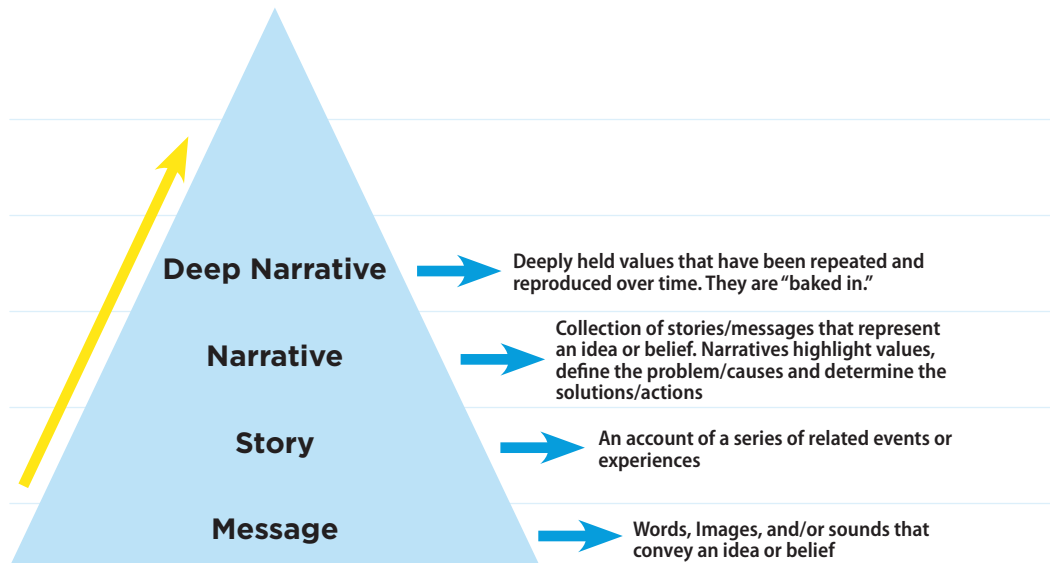
Advancing health equity

The devastating toll of COVID-19 on communities who are minoritized and or historically marginalized, coupled with worldwide protests against racism and other systems that exclude, has brought many people and a wide spectrum of institutions into conversations about racial justice and health equity. Many groups are now examining the dire statistics detailing inequities (or *injustices*) in health, the root causes of those statistics, and the role our institutions have played in producing and perpetuating this harm.[5,6] This effort involves

confronting the mounting evidence of the health effects 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.

Figure 1: The Narrative Ecosystem

Deep Narrative → Deeply held values that have been repeated and reproduced over time. They are "baked in."

Narrative → Collection of stories/messages that represent an idea or belief. Narratives highlight values, define the problem/causes and determine the solutions/actions

Story → An account of a series of related events or experiences

Message → Words, Images, and/or sounds that convey an idea or belief

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]

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[*]   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, defined 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; influencing 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 defined 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 fields, including critical race theory (defined 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.

We begin with an acknowledgement that health inequities—defined as differences in health that are avoidable, systematic, measurable and unjust—are well documented throughout the U.S.[2,10] They are perhaps most tangible in epidemiological indicators, including life expectancy, infant mortality and other measures of population health.[11] Yet as health services research shows, inequities are also evident in the health care system itself—through bias, prejudice and stereotyping on the part of health care providers,[12] racial bias in the tools used to make clinical decisions,[13] and through policies and systems that limit access to quality treatment.[14,15]

Health inequities are directly related, indeed, *produced and reinforced* by inequities in other parts of society, including the workplace, housing, education and criminal justice systems. These inequities are produced by historical, contemporary, individual and collective decisions made by people; they are not natural or inevitable.

Achieving health equity is not a utopian dream. On the contrary, we have the technical capacity and material resources to make health equity a reality—to assure that all communities have the conditions, resources, opportunities and power to attain optimal health, and to know that health is a human right. Among the first steps in this work is developing an honest account of our deeply ingrained mental models and everyday assumptions about health and society. For this to occur, physicians and other health care workers, who first and foremost care for patients and their medical needs, must develop a critical consciousness of the root causes and structural drivers of health inequities in their communities.[4,16]

We are convinced that learning to notice and question dominant narratives is an important step toward disrupting and correcting them, and a vital component of health equity work. One way to make dominant narratives visible is to develop a capacity to critically examine the language we use in our communication. This guide is intended to raise questions about language and commonly used phrases and terms, with the goal of cultivating awareness about dominant narratives and offering equity-based, equity-explicit, and person-first alternatives.

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 offer 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 definitive list of "correct" terms, but rather, to give some guidance on equity-focused, person-first language. For example, one might commonly describe someone as "a diabetic." A person-first 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-first language seeks to center the lived experience of people and communities without reinforcing labels, objectification, stigmatization and marginalization. Along these lines—consider the ways that the word "community" is sometimes used, suggesting that "the community" is monolithic. Words reflect our thinking and shape our thinking; it is to our benefit 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 five key principles:

1. Avoid use of adjectives such as "vulnerable" and "high-risk."
2. Avoid dehumanizing language. Use person-first 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.

Table 1: Key Principles and Associated Terms

Key principles	Instead of this ...	Try this ...

Avoid use of adjectives such as vulnerable, marginalized and high-risk. These terms can be stigmatizing. These terms are vague and imply that the condition is inherent to the group rather than the actual causal factors. Try to use terms and language that explain why and/or how some groups are more affected than others. Also try to use language that explains the effect (i.e., words such as impact and burden are also vague and should be explained).	• Vulnerable groups
	• Marginalized communities
	• Hard-to-reach communities
	• Underserved communities
	• Underprivileged communities
	• Disadvantaged groups
	• High-risk groups
	• At-risk groups
	• High-burden groups
		• Groups that have been economically/socially marginalized
		• Groups that have been historically marginalized or made vulnerable; *historically* marginalized
		• Groups that are struggling against economic marginalization
		• Communities that are underserved by/with limited access to (specific service/resource)
		• Under-resourced communities
		• Groups experiencing disadvantage because of (reason)
		• Groups placed at increased risk/put at increased risk of (outcome)
		• Groups with higher risk of (outcome)
		• For scientific publications:
		  – Disproportionately affected groups
		  – Groups experiencing disproportionate prevalence/rates of (condition)

Avoid dehumanizing language. Use person-first language instead. Describe **people** as having a condition or circumstance, not being a condition. A case is an instance of disease, not a person. Use patient to refer to someone receiving health care. **Humanize those you are referring to by using people or persons.**	• The obese or the morbidly obese • COVID-19 cases • The homeless • Disabled person • Handicapped • Inmates • Victims • Cases or subjects (when referring to affected persons) • Individuals	• People experiencing (health outcome or life circumstance) • People with obesity; people with severe obesity • Patients or persons with COVID-19 • People who are experiencing (condition or disability type) • Person with mobility disability • Person with vision impairments • People who are experiencing homelessness • Survivors

Remember that there are many types of subpopulations. General use of the term minority/minorities should be limited, in general, and should be defined when used. Be as specific as possible about the group you are referring to (e.g., be specific about the type of disability if you are not referring to people with any disability type).	• Minorities
	• Minority
	• Ethnic groups
	• Racial groups
		• Specify the type of subpopulation:
		  – (People from) racial and ethnic groups
		  – (People from) racial and ethnic minority groups
		  – (People from) sexual/gender /linguistic/religious minority groups
		  – (People with/living with) mobility/cognitive/vision/hearing/independent living/self-care disabilities

Avoid saying target, tackle, combat or other terms with violent connotation when referring to people, groups or communities. These terms should also be avoided, in general, when communicating about public health activities.	• Target communities for interventions • Target population • Tackle issues within the community • Aimed at communities • Combat (disease) • War against (disease)	• Engage/prioritize/collaborate with/serve (population of focus) • Consider the needs of/Tailor to the needs of (population of focus) • Communities/populations of focus • Intended audience • Eliminate (issue/disease)
Avoid unintentional blaming. Consider the context and the audience to determine if language used could potentially lead to negative assumptions, stereotyping, stigmatization, or blame. However, these terms may be appropriate in some instances.	• Workers who do not use PPE • People who do not seek healthcare	• People with limited access to (specific service/resource) • Workers under-resourced with (specific service/resource)

Adapted from: "Health Equity Guiding Principles for Unbiased, Inclusive Communication" (CDC).

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.

Table 2: List of Commonly Used Words/Phrases and Equity-Focused Alternatives

Readers will find a mix of terms in this table. Some terms are uniformly offensive, and we support efforts to eliminate their use (e.g., "illegal immigrant" or "ex-con"). Other terms are appropriate in some contexts but have limitations, and equity-focused alternatives exist that can be considered in their place (e.g., "disparities" versus "inequities," or "cultural competence" versus "structural competence"). Our primary goal is not to provide a definitive list of incorrect and correct terms, and we acknowledge that language evolves over time. With open and ongoing communication, awareness and humility, we can work together to refine language in the pursuit of equity.

Commonly used	Equity-focused alternative	Reason
black	Black	After years of debate, the Associated Press recommendation is clear: lowercase black denotes a color, not a person. Their style guide aligns with the long-standing capitalization of other racial and ethnic identifiers such as Latino and Asian American.[18] The Associated Press recommends not capitalizing white, recognizing that "white people generally do not share the same history and culture, or the experience of being discriminated against because of skin color."[19] In contrast, the *AMA Manual of Style* currently recommends capitalizing *both* Black and White.[20] Pressure may well mount for this to change.

Commonly used	Equity-focused alternative	Reason
Caucasian	white	The term Caucasian originated in the 18th century, with the work of the German anatomist Johann Blumembach. He developed a system of racial classification after visiting the Caucasus Mountains, by the Caspian and Black seas. Blumembach declared the inhabitants of that region "the most beautiful in the world," an ideal type of human based on "God's image," and extended that category to include all light-skinned peoples from this region and Europe. Blumembach went on to name four other races in the world, which he considered degenerate forms of what he called "God's original creation." He categorized Africans, excluding light-skinned North Africans, as "Ethiopians" or "black." He divided non-Caucasian Asians into two separate races: the "Mongolian" or "yellow" race of Japan and China, and the "Malayan" or "brown" race, which included Aboriginal Australians and Pacific Islanders. And he called Native Americans the "red" race.[17] Blumembach's racial classification system influenced many scientists of the time as well as the U.S. legal system through the 1790 Naturalization Act, which restricted who was eligible to become a naturalized citizen in this country.
Cultural competence	Cultural humility/ cultural safety/ structural competence	Cultural competence has been a component of medical education for the past 30 years. The cultural competence frameworks seeks to promote "culturally sensitive" practice, and describes the trained ability of a clinician to identify cross-cultural expressions of illness and health.[21,22] Yet this framework has been criticized on several grounds: it presents overly reductionist, simplistic and static depictions of culture, often reduced to race/ethnicity, and frames culture and race/ethnicity as residing only in the "Other," normalizing dominant white culture. Perhaps most negatively, cultural competence "is understood as something that can be attained, individualizing failure to do so. This misconstrues structured power relations which cannot be altered individually. Worse yet, competence is measured in terms of learner confidence and/or comfort, which may have little to do with working effectively across differences."[23]

In contrast, *cultural humility* is based on a "lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations."[24]

A second alternative is offered by the structural competency framework developed by Jonathan Metzl and Helena Hansen.[22] It redefines cultural competency in structural terms, and calls for training in "five core competencies: (1) recognizing the structures that shape clinical interactions; (2) developing an extra-clinical language of structure; (3) rearticulating "cultural" formulations in structural terms; (4) observing and imagining structural interventions; and (5) developing structural humility."[22]

Another valuable alternative to cultural competence is the concept of *cultural safety*, developed in the 1980s in response to discontent with medical care in New Zealand. Cultural safety goes beyond the basic notion of cultural sensitivity that characterizes cultural competence to focus on analyzing power imbalances, institutional discrimination, and colonial relationships as they manifest in health care. Cultural safety calls on medical professionals and health care institutions to create spaces for patients to receive care that is responsive to their social, political, linguistic, economic and spiritual realities. Culturally *unsafe* practices, in contrast, are actions that diminish, demean or disempower the cultural identity and well-being of patients.[25,26] |

Commonly used	Equity-focused alternative	Reason
Disadvantaged/ under-resourced/ under-served	Historically and intentionally excluded; disinvested	These terms should be used with caution and consideration. "Disadvantaged" has been used for many decades and is now widely contested for supporting a deficit-based, rather than asset-based, model of people and communities. Many people find the term pejorative, and it has been used as an implicit descriptor for minoritized and historically marginalized communities. In some circumstances, "under-resourced" and "under-served" are used—both terms begin to describe the historical disinvestment experienced by some communities—but these terms have also been critiqued, as some communities are "overserved," with services and resources that are not working or lack coordination. At the same time, "disadvantaged" is still sometimes used to describe processes of exclusion, recognizing that there are dimensions beyond resourcing and service receipt that are not necessarily well capture by "under-resourced" or "under-served". Alternatives include "historically and intentionally excluded" and "disinvested."
Disparities (or inequalities)	Inequities	Disparities typically refer to differences (though in some uses of this term, including in *Healthy People 2020*, the term is explicitly linked to economic, social, or environmental disadvantage).[27] Health "inequities," in contrast, are explicitly defined as health differences that are avoidable, unnecessary, unfair and unjust.[2]
Equality	Equity	Equality as a process means providing the same amounts and types of resources across populations. Seeking to treat everyone the "same," this ignores the historical legacy of disinvestment and deprivation through policy of historically marginalized and minoritized communities as well as contemporary forms of discrimination that limit opportunities. Through systematic oppression and deprivation from ethnocide, genocide, forced removal from land and slavery, Indigenous and Black people have been relegated to the lowest socioeconomic ranks of this country. The ongoing xenophobic treatment of undocumented brown people and immigrants (including Indigenous people disposed of their land in other countries) is another example.[28] Intergenerational wealth has mainly benefited and exists for white families. The "equality" framework, as applied, also fails individual patients and communities. For example, high-quality and safe care for a person with a disability does not translate to 'equal' care. A person with low vision receiving the 'same' care might receive documents that are illegible, depriving them of the ability to safely consent to and participate in their treatment.

Commonly used	Equity-focused alternative	Reason
Ex-con/felon	Formerly incarcerated/ returning citizen/ persons with a history of incarceration	"Formerly incarcerated" humanizes the individual. Consider this insight from *An Open Letter to Our Friends on the Question of Language*, by Eddie Ellis: "One of our first initiatives is to respond to the negative public perception about our population as expressed in the language and concepts used to describe us. When we are not called mad dogs, animals, predators, offenders and other derogatory terms, we are referred to as inmates, convicts, prisoners and felons. All terms devoid of humanness which identify us as 'things' rather than as people. These terms are accepted as the 'official' language of the media, law enforcement, prison industrial complex and public policy agencies. However, they are no longer acceptable for us and we are asking people to stop using them." "In an effort to assist our transition from prison to our communities as responsible citizens and to create a more positive human image of ourselves, we are asking everyone to stop using these negative terms and to simply refer to us as PEOPLE. People currently or formerly incarcerated, PEOPLE on parole, PEOPLE recently released from prison, PEOPLE in prison, PEOPLE with criminal convictions, but PEOPLE."[29] (emphasis in original quote)
Fairness	Social justice	An important distinction separates the ideas of social justice, which is a standard of rightness, and fairness, which is a more limited concept. The latter pays no attention to how power relations in society establish themselves but primarily emphasizes outcomes within a pre-given set of rules. For instance, to focus on the allocation of society's resources or benefits (income, wealth, natural resources) is itself the result of structures of power and the processes that produce such outcomes. Fairness is a hope for an outcome. In the legal system, one could say that each side in a trial having a lawyer to represent them is fair. But the justice system may favor the wealthy over the poor.
Hispanic/Latina/ Latino/Latinx	Hispanic/Latina/Latino/ Latinx	Hispanic and Latina/Latino are often used interchangeably in the U.S. to describe the ethnic identity of people with Latin American or Spanish ancestry. The term Hispanic has been used by the U.S. government since the 1970s and is used to signify descendants of Spain. The terms Latino/Latina gained popularity in the 1990s in both U.S. government data collection and popular discourse because it was deemed more inclusive of Indigenous and African descendants in the Latin American continent, and it does not center Spanish descent or language fluency. Latinx is a newer term that also describes 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 origin. 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, as well as terms that signify Indigenous heritage. 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 specific communities involved in discussion to ask their preference.

Commonly used	Equity-focused alternative	Reason
Illegal immigrant	Undocumented immigrant	"Illegal" is a dehumanizing, derogatory term used to describe a person who resides in a country without proper documentation. No human being is illegal. "Undocumented" is a common and widely accepted term. Migrant rights literature also includes "informally authorized migrant," a term that disrupts the idea that someone is missing or has failed to acquire proper documents (a discourse that individualizes the underlying issue), revealing that some migrants are actively denied resources (a structural issue).[30]
Indians	Native peoples/ Indigenous peoples/ American Indian and Alaska Native	Plurality (i.e., Native peoples) is often preferred, to avoid the homogenization of Indigenous peoples that so often occurs in dominant narratives. Native peoples/Indigenous peoples/American Indian should be used instead of "Indian." According to the National Museum of the American Indian, "The consensus, however, is that whenever possible, Native people prefer to be called by their specific tribal name. In the United States, Native American has been widely used but is falling out of favor with some groups, and the terms American Indian or Indigenous American are preferred by many …"[31] First Nations and First Nations peoples are accepted terms worldwide to refer to Indigenous peoples. It is critical to understand and acknowledge the diversity among Indigenous Peoples along with their strengths and the structural challenges they endure. To determine the term that is most appropriate for your context, ask the person or group which term they prefer. When referring to Native groups, use the terminology the members of the community use to describe themselves. The Native American Journalists Association has published guidance on best practices for avoiding common stereotypes that readers may find useful.
Master/slave (particularly in software/tech)	Alternatives include active/standby, writer/ reader, and leader/ follower.[32]	Master and slave have been used for decades in software and tech discourse to describe processes and tools where one component controls another.[32] In 2018, the popular software language Python dropped both terms from use. In 2020, many people and groups in tech started to question the use of these terms.[32]
Minority	Historically marginalized or minoritized or BIPOC	Minority means "less than" and is now considered pejorative. In addition, groups have been made minorities by dominant culture and whiteness, thus minoritized. Importantly, marginalization and minoritization occurs not just with racial identities, but with other identities as well, including gender. At stake is the connection of status to power differentials. Minoritization is associated with a loss of power. BIPOC (Black, Indigenous, and people of color) is a relatively new term, expanding the previously used acronym POC (people of color). The term gained popularity in 2020 and is used to "to highlight the unique relationship to whiteness that Indigenous and Black (including African American) people have, which shapes the experiences of and relationship to white supremacy for all people of color within a U.S. context."[33] The acronym BIPOC is not without critics, however, and should not be used in quantitative reporting to unnecessarily aggregate groups; instead, disaggregated data should be used to depict the experiences of groups.

Commonly used	Equity-focused alternative	Reason
Non-compliance	Non-adherence	Compliance describes purely passive behavior in which patients follow instructions. Non-compliance places blame for treatment failure solely on patients. Adherence is the preferred term, and can be defined as "a process, in which the appropriate treatment is decided after a proper discussion with the patient. It also implies that the patient is under no compulsion to accept a particular treatment, and is not to be held solely responsible for the occurrence of non-adherence."[34] Non-adherence may come from many sources, including frustration and legitimate mistrust of health care, structural barriers that limit availability and accessibility of medications (including cost, insurance barriers and pharmacy deserts), time and resource constraints (including work hours, family responsibilities), and lack of effective communication about severity of disease or symptoms.
Race-based	Race-conscious	The practice of using race as a biological construct (i.e., racial essentialism) results in harm for historically marginalized and minoritized groups, exacerbating health inequities. New AMA policy passed in November 2020 explicitly calls for ending the practice of using race as a proxy for biology in medical education, research and clinical practice. Race-based protocols exist and are being challenged in a wide range of areas: eGFR (estimated glomerular filtration rate), BMI risk for diabetes, FRAX (fracture risk assessment score), PFT (pulmonary function test), UTI (urinary tract infection), ASCVD (atherosclerotic cardiovascular disease) and more.[35] In contrast to a race-based approach, a race-conscious framework can promote anti-racist practices, shifting focus from race to racism in all its forms.
Sex/gender/gender identity	Sex assigned at birth/gender/gender identity	Sex and gender are different concepts that are often mistakenly used interchangeably. Indeed, many people confuse sex, gender, and gender identity. Sex, or more precisely, "sex assigned at birth" is a label typically assigned by a doctor at birth based on the genitals you're born with. This may or may not align with how a person identifies themselves. Gender, in contrast, refers to the "social, psychological, and emotional traits, attitudes, norms and behaviors, often influenced by society's expectations, that classify someone as man, woman, both, or neither."[36] Gender identity refers to how people conceptualize themselves as gendered beings, including one's innate and personal experience of gender. This may or may not align with one's gender expression or biological sex. Per the American Academy of Pediatrics, gender identity is "one's internal sense of who one is, which results from a multifaceted interaction of biological traits, developmental influences, and environmental conditions. It may be male, female, somewhere in between, a combination of both, or neither (i.e., not conforming to a binary conceptualization of gender)."[37]
Slave	Enslaved person	"Enslaved person" separates a person's identity from their circumstance; the term describes humans first and foremost, acknowledging that they are not a commodity, but rather a person who has had slavery imposed upon them. Similarly, "enslaver" is now recommended in many contexts over "owner" or "master"—terms that empower the enslaver and dehumanize the enslaved person.

Commonly used	Equity-focused alternative	Reason
Social problem	Social injustice	To refer to racism, for example, as a "problem" is to not only diminish its seriousness but also to potentially blame people for their own marginalization. Referring to racism as a social problem further presupposes a possible solution through conventional, technical or bureaucratic approaches.
Underrepresented minority	Historically marginalized, minoritized, or excluded	The term "underrepresented minority" (URM) has been used in many fields, including medicine, to refer to the low participation rates of particular racial and ethnic groups (Black/African American, Latinx, Native American/Alaska Native). There is now growing awareness of the limitations of this term. To be "underrepresented," one is "not enough" and "below." The term URM unnecessarily aggregates and confounds the experiences of diverse groups and renders invisible the processes that lead to exclusion. And a general focus on URM betrays a deficit framework that inhibits asking direct questions about what leads other groups to be overrepresented.
Vulnerable (or disadvantaged)	Oppressed (or made vulnerable or disenfranchised)	Vulnerable is a term often used to describe groups that have increased susceptibility to adverse health outcomes. We even describe individual people as vulnerable or not, often based on socioeconomic status. If we pause to examine our taken-for-granted narrative, we see that vulnerability can be understood in very different ways. In this case, as a characteristic of people or groups. But what if we shift the narrative from an individualistic lens to an equity lens? In doing so, we begin to ask questions about the structural origins of vulnerability. Vulnerability is the result of socially created processes that determine what resources and power groups have to avoid, resist, cope with, or recover from threats to their well-being. Instead of stigmatizing individuals and communities for being vulnerable or labeling them as poor, we begin to name and question the power relations that create vulnerability and poverty. People are not vulnerable; they are made vulnerable. Along these lines, one might refer to neighborhoods and communities as systematically divested rather than "vulnerable" or "poor."
White paper/ whitelist/white label/blacklist/ blackball/blackmail	Reconsider need for white/black adjectives (e.g., white/blacklist can easily be changed to allow/deny list)	There are many terms in the English language that indicate white privilege. For example, a "whitelist" denotes a list of approved or favored terms; a "blacklist" denotes people, places, and things that are viewed with suspicion or disapproval.

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 about cultural norms in the communities they serve. Narratives shape public opinions regarding health care reform and guide our interpretation of health equity statistics, along with the questions we ask about the causes of adverse health outcomes.[†]

Consider the narratives that come to mind when you begin to think of the following situations:

- A 44-year-old Puerto Rican man comes to a free clinic with acute exacerbation of back pain. He has diabetes and hypertension. He is hesitant to seek health care. He expresses a mistrust of institutions because of negative experiences with the criminal justice system.[39][‡]

- A 60-year-old Black woman presents at the emergency department of a community hospital in the south side of Chicago with a breast lump. She does not have a regular doctor.[14]

Narratives shape what questions we ask in these cases and what solutions we might develop. They even shape our descriptions of the situation, what attributes of the person and the situation are emphasized in our summary of the cases. The circumstances of the 44-year-old man suffering from back pain ultimately requires us to grapple with the immediate concern of back pain, the longer term concerns about controlling his diabetes and hypertension, *and* the structural violence associated with hyperincarceration.[39] In the case of the 60-year-old woman, we are tasked with helping her access appropriate testing and treatment while confronting the structural racism that has shaped the economic opportunities as well as limited access to quality treatment in her community.[14] Even the use of "free clinic" puts a pejorative narrative that undermines equity and exposes the reality of a two-tier, segregated health care system. Both cases represent an opportunity to "shift the narrative"—from the traditional biomedical focus on the individual and their behavior to a health equity focus on the well-being of communities, as shaped by social and structural drivers.

[†] Racial and Ethnic Disparities in Health Care H-350.974

[‡] Improving Healthcare in Hispanic Populations in the United States 2008 - H-350.975, Racial and Ethnic Disparities in Healthcare 2019 H- 350.974, Improving the Health of Black and Minority Populations 2011- H-350.972, Redefining AMA's Position on ACA and Healthcare Reform 2017 D-165.938.

This guide discusses how dominant narratives obscure historical legacies and harmful power structures that affect 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 different 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 create vulnerability. People are not vulnerable; they are made vulnerable.

Similarly, it is not for the advantaged in society to "empower" communities; an equity lens allows us to recognize that systems of power and oppression (including white supremacy, homophobia, xenophobia, ableism) shape institutional policies and living conditions that systematically harm populations. An equity lens opens up new and profound ways of framing questions, as explored in Table 3.

Table 3: Changing the Questions We Ask

Conventional	Health equity perspective
What interventions can address health disparities?	What generates health inequity in the first place?
What social programs and services are necessary to address health inequity?	What types of social change is necessary to confront health inequity?
How can individuals protect themselves against health problems?	What kind of public collective action is necessary to confront health inequity across identifiable populations?
How can we promote healthy behavior?	How can we democratize land use policies through greater public participation to ensure healthy living conditions?
How do we treat the consequences of health inequity?	How do we act on root causes of inequality to meet human need?
How can we create more resilient communities?	How can public health protect communities from disinvestment, redlining, predatory lending, serving as targets for hazardous waste?
What are the ways public health can adapt innovative practices to changing times?	What are the ways public health, with their allies, can organize for social change directed to meeting human need for health and well-being?

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

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§   Racial and Ethnic Disparities in Health Care H-350.974

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]

Examining dominant narratives

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":

Table 4: Features of Dominant Narratives in Everyday Life

Feature	Example
Dominant narratives absolve people and institutions of responsibility for social injustice.	Economic crises are said to be caused by markets, mistakes, unfortunate events, rather than decisions and choices made by institutions and networks of power.
Dominant narratives justify policy decisions by quantifying them with a precise cost. The purpose is to give the appearance of objectivity, even when the value of social goods, such as education, have value and benefit that cannot simply be determined by its cost as an ordinary commodity.	Cost-benefit analysis used to determine market values or prices to things including clean air, water quality and non-renewable natural resources.
Dominant narratives use economic indicators—rather than social indicators of well-being—as main measures of value and importance, including human life.	Dow Jones Industrial Average, productivity, consumer confidence, GDP, earnings ratios.
Dominant narratives use coded racial language to feed on insecurities of the white majority; they stoke resentment and distract from threats that might otherwise unite people across racialized groups, such as concentrated wealth and the destruction of the environment.	Coded racial words and phrases like inner-city, colorblind, states' rights, welfare queen, tough on crime, and government handout are used to denigrate public services that are needed and paid for by all but become associated with minoritized groups.
Dominant narratives underwrite social divisions and drive wedges among racial groups, workers, genders and other groups so that they do not see their common concerns.	Relies on othering, stigmatizing, categorizing, and creating competition, hierarchies and divisions by social status.
Dominant narratives position people as consumers rather than citizens; choices are defined through individual consumption rather than broad social policy, serving as a substitute for democracy.	Freedom is defined as choice to buy, sell, own, have purchasing preferences, yet not as having civil rights, or making democratic decisions based on living conditions or social accountability
Dominant narratives blame people for their own condition by placing the cause of their problems on the individuals themselves, and not on systems that generate inequity.	Causes of illness are due to personal irresponsibility.

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, fiction 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 reflects 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 significant 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 off work, or not being able to secure affordable childcare to participate in an activity or follow up appointment. Conventional and equity-focused root-cause narratives are illustrated in Table 5:

Table 5: Contrasting Conventional (Well-intentioned) Phrasing with Equity-focused Language that Acknowledges Root Causes of Inequities

Conventional	Revision
Native Americans have the highest mortality rates in the United States.	Dispossessed by the government of their land and culture, Native Americans have the highest mortality rates in the United States.
Low-income people have the highest level of coronary artery disease in the United States.	People underpaid and forced into poverty as a result of banking policies, real estate developers gentrifying neighborhoods, and corporations weakening the power of labor movements, among others, have the highest level of coronary artery disease in the United States.
Factors such as our race, ethnicity or socioeconomic status should not play a role in our health.	Social injustices including racism or class exploitation, e.g., social exclusion and marginalization, should be confronted directly, so that they do not influence health outcomes.
For too many, prospects for good health are limited by where people live, how much money they make, or discrimination they face.	Decisions by landowners and large corporations, increasingly centralizing political and financial power wielded by a few, limit prospects for good health and well-being for many groups.

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

Dominant narratives' power to override alternative viewpoints precludes the imagining of a more just society. Omnipresent and insidious, dominant narratives can slip inside our heads and actions without our awareness, as the Grassroots Policy Project observes.[44] Dominant narratives are created and advanced for a purpose and can endure for generations. Yet dominant narratives lose some of their power when they are unmasked for what they are—*tools for creating and reinforcing power*.

Consider, for example, the workings of the following two dominant narratives (which hold power in society overall and in health in particular), the narrative of race and the narrative of individualism.

¶   Racial and ethnic disparities in health care H-350.974

The narrative of race

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 historically marginalized and minoritized groups, exacerbating health inequities. Race-based protocols currently exist (and are being challenged) in a wide range of areas: eGFR (estimated glomerular filtration rate), BMI risk for diabetes, FRAX (fracture risk assessment score), PFT (pulmonary function test), UTI (urinary tract infection), ASCVD (atherosclerotic cardiovascular disease) and more. As seen in Figure 2, race-based medicine leads directly to racial health inequities (adding to and compounding the health effects of racism that exists outside of the medical sector), with harmful practices in research, medical education and clinical practice.[35]

Figure 2: How Race-based Medicine Leads to Racial Health Inequities Through Research, Medical Education and Clinical Practice
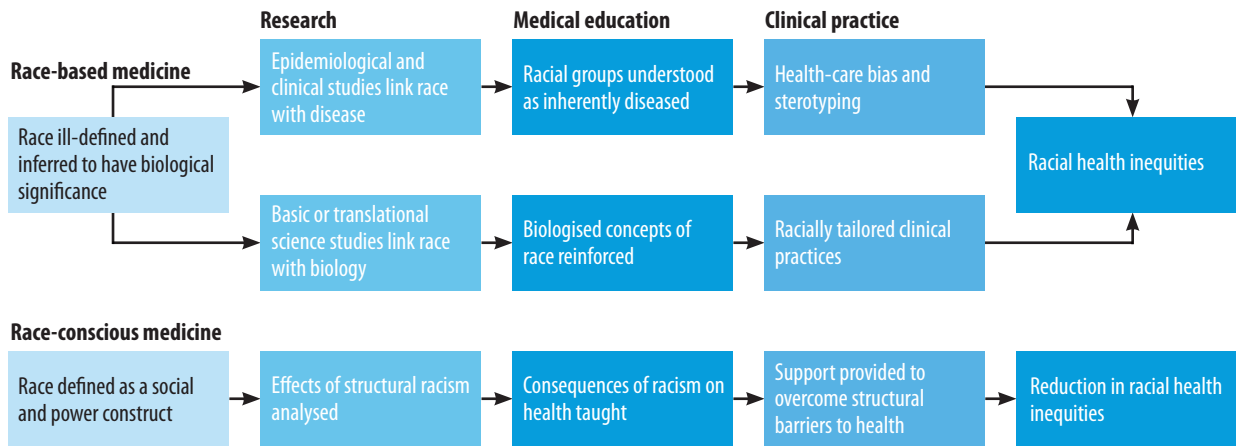
Source: Cerdeña, Plaisime, and Tsai, 2020. *The Lancet*.[35] Used with permission.

Directly challenging dominant narratives about race, new AMA policies passed in 2020 explicitly (a) denounce racism as a public health threat; (b) call for the elimination of race as a proxy for ancestry, genetics, and biology in medical education, research, and clinical practice; and (c) decry racial essentialism in medicine.[46] Also in 2020, the AAMC released a new framework, "Addressing and Eliminating Racism at the AAMC, in Academic Medicine, and Beyond," that outlines concrete steps the AAMC will take to address structural racism across all fronts: as individuals, as an association, as part of the academic medicine community, and as members of society.[47] Senior leaders in medical education have worked with the AAMC to provide guidance to educators on actions towards anti-racism in medical education including acknowledging the misuse of race throughout medical training that creates an improper connection for learners and perpetuates the theory of biologically derived racial differences (racial essentialism).[48,49]

This is a true turning point. The use of race as a proxy variable across centuries of medical, epidemiological, and genetics research has contributed to histories of painful interventions, delayed medical treatment, erroneous medical decision-making, and has oftentimes locked historically marginalized and minoritized peoples out of life-enhancing or life-saving healthcare delivery.[50] A biological narrative of race is threaded within the fibers of our oldest social institutions, and the policies that govern them.[51]

The implications of this are profound. As explained by Dorothy Roberts:

> "There is a long history of using a biological definition of race to make social inequities seem natural—the result of inherent difference instead of societal injustice. … The claim that race-based biotechnologies will shrink the gap based on genetic difference is a powerful way to deflect concerns about their unjust social impact and the social inequality that actually drives poor health in marginalized/minoritized groups. We should be against an approach that promotes individual health through technological cures as a way of ignoring larger social inequities."[52]

Yet narratives that reinforce racial essentialism exist everywhere in society, expressed in beliefs, symbols, stereotypes, values, and institutional practices in banking, education, criminal justice, and in the health care system itself.[44,53,54] These narratives constantly shift and adapt as conditions change and serve to rationalize the privileges of racism that sustain white supremacy. They perpetuate cumulative advantage and unearned benefits for whites, often blaming people of color for their own conditions, avoiding social accountability for racist oppression. Thus, racism functions as a "fundamental cause of disease," impacting multiple health outcomes through various pathways: close off one and others are there to maintain the relationship between racism and health.[55]

One does not have to read very far in the medical literature before coming across research on racial differences in health that posit biological or genetic reasons for observed differences. Rhea Boyd et al. have issued a powerful rebuke of this practice: "In the absence of a rigorous examination of racism, assertions that unmeasured genetic or biological factors may account for racial differences in health outcomes are troublingly frequent."[56] They draw out critical implications:

> "The academic publication process, through authors, reviewers, and editors, has legitimized scholarship that obfuscates the role of racism in determining health and health care. This renders racism less visible and thus less accessible as a preventable etiology of inequity. It enables the health care infrastructure to unduly blame individual patients for the neglect and harm of systemic processes that undergird individual and population health inequities. It subjects countless patients, spanning generations in communities of color, to ineffective behaviorist approaches to problems that are actually institutional in nature."[56]

It is past time to shift the narrative from *race to racism*—recognizing, as critical race scholarship teaches us, that race is a socially-constructed system for producing and reinforcing power. Again, Dorothy Roberts explains and directly challenges physicians:

> "… [R]ace is not a biological category that naturally produces these health disparities because of genetic difference. Race is a social category that has staggering biological consequences … because of the impact of social inequality on people's health. … *What if doctors joined the forefront of a movement to end the structural inequities caused by racism, not by genetic difference?*" (emphasis added)[57]

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.

The narrative of individualism

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] In health care, this narrative appears as an over-emphasis on changing individuals and individual behavior instead of the institutional and structural causes of disease.[58]

This narrative acknowledges that class inequities may be unfortunate, but falls short of declaring them unjust, thus obscuring political, structural and social determinants of health inequities. Diseases become the main target rather than the social and economic conditions that produce health inequities.[59] This focus ignores the role of political struggle in the advances that have been made over time.[60] For example, the major advances in life expectancy in the early 20th century resulted from the actions of social movements to eliminate child labor, institute housing and factory codes, and raise living standards, not advances in technology or economic growth.[60] Health promotion in medicine and public health typically means educating people as individuals about their health without acknowledging the influence of living conditions, which are themselves conditioned upon

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 purpose of a health equity-based narrative

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 effects 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 effects 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 influencing 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 fixes 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 efforts 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 reflect, 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, gentrification, 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 narrative

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, "Building Narrative Power for Racial Justice and Health Equity."[38] The report concluded:

- Closer ties between public health and social movements promoting racial, economic, and social justice are critical for nurturing a narrative of health directed toward addressing social and political inequalities, not individual behavior or perceived cultural differences.

- Racial justice and health equity require action on a structural level. A solution cannot be individually based, because the root causes of inequity do not lie within the control of individuals.

- Success depends on developing narratives that move and motivate both constituents and colleagues.

The purpose is to make injustices that perpetuate health inequity visible. An effective, compelling health equity narrative is essential to transform power, end dominant privilege, and provide meanings that will galvanize possibilities for equitable cultural change.

Learning to see and think critically through dialogue

We now turn to a more explicit discussion of the skills and sensitivities necessary for developing narrative transformation through critical thinking and active dialogue.

For our purposes, critical thinking and analysis is an ongoing, disciplined, evaluative process of learning about the social and political dynamics of how the world works. It requires attentiveness to the big picture: to social context and unexamined assumptions and preconceptions (about myths, stereotypes, power) that expose social and political contradictions and social injustice. Such an awareness prepares us to resist the *normalization* of dominant norms and develop effective strategies to oppose them. In that sense it can be said to be emancipatory, enhancing people's self-determination. This is done most effectively with a sense of what structural competency scholars call "structural humility," recognizing that shifting narratives is the beginning, rather than the end, of difficult and complex conversations and collaborations.[22,63]

Critical thinking calls for focused understanding of the influence of structures and institutions, especially how they benefit or oppress us. One objective is to end our own complicity in sustaining advantage or privilege. This involves recognizing the benefits we gain by not noticing or investigating the power of dominant narratives.

We believe there are several basic principles for developing and sustaining this critical perspective:

- Think keenly
- Listen deeply
- Act intentionally
- Reflect frequently

Think keenly. The act of thinking leads us to gain meaning through reasoning. In the affective and passionate realm of dialogue, we are often tempted to push for truth and "rightness." Yet, the focus of dialogue should be meaning. Truth does not by itself resolve conflict, meaning does.[64]

Listen deeply. In authentic dialogue participants must do more than hear each other, they must strive to understand and recognize one another in their responses. They also might do well to consider the context of the historical legacies and social and economic conditions under which people live while engaging in dialogue.

Act intentionally. Dialogue is action; dialogue is doing; dialogue initiates change. What we say is the first step in action. Using dialogue as a strategy for change eliminates the need to convince or compel other participants, and allows us to focus instead on working together to find meaning, inviting differences of opinion.

Reflect frequently. Approach this work with a sense of humility and openness to new ideas every day.

Conclusion

We believe that naming and disrupting dominant narratives that obscure the fundamental causes of health inequities is a vital act. Yet the work must not stop there. Physicians and health care workers will also need to ensure behavior and practice change, establish meaningful collaboration with and advocacy for communities that have been historically marginalized, and participate in multi-sector partnerships to address societal systems of oppression. Researchers will need to re-examine taken-for-granted conventions in grant writing and scholarly publishing—identifying and challenging dominant narratives that are deeply rooted in those powerful systems. We can all contribute to elevating the voices and ideas of those most proximal to experiencing injustice, and to ensuring systems meet patients' individual-level medical and social needs. We can work together, advocating for elimination of the social, structural, and political drivers of health inequities and the systems of power and oppression that sustain them, and perhaps most importantly, continually pushing our own perceived boundaries to reimagine a just and liberated future.

Important resources

CDC's "Health Equity Guiding Principles for Inclusive Communication" (available at https://www.cdc.gov/healthcommunication/Health_Equity.html*) toolkit provides principles, resources, and specific 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.

Part 3:
Glossary of key terms

In this glossary, we provide an overview of key terms and concepts that are frequently used in health equity discussions. It is by no means exhaustive, nor is it a definitive list of correct/incorrect answers. Rather, it is intended to serve as a starting point for reflection. It is a guide on current usage of important terms and will be updated over time. Whenever possible, we cite authoritative sources and introduce ongoing debates over definitions.

Able-bodied

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.

Ableism

Discrimination of people with disabilities based on the belief that typical abilities are superior. Like racism and sexism, ableism classifies entire groups of people as "less than," and structures opportunity to advantage some and disadvantage others.

Affirmative action

A term describing policies adopted since the 1960s that require "affirmative" (or positive) actions be to taken to ensure people of color and women have opportunities equal to those of white men in the areas of promotions, salary increases, school admissions, financial aid, scholarships and representation among vendors in government contracts. Although they have been effective in redressing injustice and discrimination that persisted in spite of civil rights laws and constitutional guarantees, the policies have been attacked because of perceived "reverse discrimination." [70]

Ally

Someone who makes the commitment and effort to recognize their privilege (based on gender, class, race, sexual identity, etc.) and work in solidarity with oppressed groups in the struggle for justice. Allies understand that it is in their own interest to end all forms of oppression, even those from which they may benefit in concrete ways.[71]

Anti-racism

The active process of naming and confronting racism by changing systems, organizational structures, policies and practices and attitudes, so that power is redistributed and shared equitably. Per Ibram X. Kendi: "The opposite of racist isn't 'not racist.' It is 'antiracist.' What's the difference? One endorses either the idea of racial hierarchy as a racist, or racial equality as an antiracist. One either believes problems are rooted in groups of people, as a racist, or locates the roots of problems in power and policies, as an antiracist. One either allows racial inequities to persevere, as a racist, or confronts racial inequities, as an antiracist. There is no in-between safe space of 'not racist.'"[72] Anti-racism is a strategy to achieve racial justice. An anti-racist is someone who is supporting an antiracist policy through their actions or expressing antiracist ideas.

Asexual

Someone who does not experience sexual attraction (asexual), or rarely experiences sexual attraction (asexual spectrum). The term does not necessarily refer to actions,

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

Asset-based (or strength-based, agency-focused) approach

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]

Assimilationist

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]

Biomedical model

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.

Biphobia

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.

Bisexual

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]

Centering (voices)

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.

Cis/Cisgender

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).

Cisgenderism

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.

Cissexism

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

to use the bathrooms appropriate for their gender identity while structuring bathrooms to accommodate cisgender people.[77]

Class

Relations of power among networked/organized social groups that direct society's major institutions (such as corporations and government authorities), material resources and investments. Classism is the systematic oppression of subordinated class groups, held in place by attitudes that rank people according to economic status, family lineage, job status, level of education and other divisions.[70]

Class conflict

A permanent division and antagonism between those who own and control capital and the resources and mechanisms of production, as well as the structures of power in society, and those who do not.

Class consciousness

The recognition by workers of their unity as a social class in opposition to capitalists and to capitalism itself.

Class society

A society with pronounced social stratification and hierarchies.

Class structure

In health research, the concept of class is often reduced to social status (usually measured by household income or educational attainment). This can be very useful in documenting social gradients in health, and quantifying the relationships between social status and health outcomes.[78] Yet describing class in this way hampers efforts to understand and confront root causes—because class is not simply an attribute of an individual or their household, but a system of social relations.[79]

Coded racial appeals (dog whistles)

The use of coded or suggestive language in political messaging to gain support from a particular group without provoking opposition. Dog whistles incorporate language which may appear normal to a general audience, but which communicates specific meanings to intended audiences. They can take the form of symbols that have previously been considered benign (and may still be used in benign was in certain contexts). Coded racial appeals suggest deep-seated stereotypes without emphasizing race—"welfare queen" is an example of this. More generally, dog whistles are "used against a group or idea that threatens traditional power structures, which in America are predominantly white, male, heterosexual, cisgender."[80]

"Colorblind" racism

Term used to argue that we live in a world where racial privilege and racial discrimination no longer exists. The concept of colorblindness is often promoted by those who dismiss the importance of race in order to proclaim the end of racism. As an example, the statement: "I don't see color" denies acknowledgment or acceptance of structural arrangements that harm some people and privilege others. According to Eduardo Bonilla-Silva, colorblind racism operates as an ideology, with four underlying "frames" or guides for interpreting information. These are: (1) abstract liberalism (using ideas associated with political liberalism, like "equal opportunity," and economic liberalism, like "choice," and "individualism," to explain racial matters); (2) naturalization (explaining racial phenomena by suggesting they are natural occurrences); (3) cultural racism (relying on culturally-based arguments to explain the standing of minorities in society); and (4) minimization (suggesting that

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

Colorism

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]

Coming out

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

Critical Race Theory

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.

Culture

Set of shared attitudes, values, goals and practices that characterize an institution, organization or group. Culture is transmitted and reinforced through tradition, art, language and ritual, among other practices. It has also been defined more broadly as a social system of meaning and custom by a group of people to assure its adaptation and survival.

Cultural appropriation

Adoption of elements of a culture that has been subordinated in social, political or economic status by a different cultural group. It may rely on offensive stereotypes, and is insensitive to how the culture of a group has been exploited by the culture in power, often for profit.[70]

Cultural competence

A component of medical education for the past 30 years. The cultural competence frameworks seeks to promote "culturally sensitive" practice, and describes the trained ability of a clinician to identify cross-cultural expressions of illness and health.[21,22] However, this umbrella term has been criticized on several grounds: it presents overly reductionist, simplistic and static depictions of culture, often reduced to race/ethnicity, and frames culture and race/ethnicity as residing only in the "Other," normalizing dominant white culture. Perhaps most negatively, cultural competence "is understood as something that can be attained, individualizing failure to do so. This misconstrues structured power relations which cannot be altered individually. Worse yet, competence is measured in terms of learner confidence and/or comfort, which may have little to do with working effectively across differences."[23]

Cultural dominance

A form of oppression that diminishes the experience, values and goals of members of groups considered of lesser worth, in other words, devaluing cultural identity. It constrains the expression of peoples' identities and culture by stereotyping** their needs, often rendering them publicly invisible. It can lead to harassment and intimidation, and marginalization.

Cultural safety

Developed in the 1980s in response to discontent with medical care in New Zealand. Cultural safety goes beyond the basic notion of cultural sensitivity that characterizes cultural competence to focus on analyzing power imbalances, institutional discrimination, and colonial relationships as they manifest in health care. Cultural safety calls on medical

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** Disparities in Health Care E-8.5; Racial and Ethnic Health Care Disparities H-140.875

professionals and health care institutions to create spaces for patients to receive care that is responsive to their social, political, linguistic, economic and spiritual realities. Culturally unsafe practices, in contrast, are actions that diminish, demean, or disempower the cultural identity and well-being of patients.[25,26]

Culture of poverty

Commonly used phrase that blames people for their own poverty and assumes that some groups have a destructive element in their culture that leads them into poverty. The assumption ignores patterns of policy and discrimination[††] that create poverty.

Deep narratives

According to the Narrative Initiative, "Deep narratives are characterized by pervasiveness and intractability. They provide a foundational framework for understanding both history and current events, and inform our basic concepts of identity, community and belonging."[81] Moreover, they "structure how entire societies interpret the way things work; they animate stories with consistent messages and meanings. Their power is reproductive; their subjects and speakers unconsciously repeat and reinforce them. Their invisibility makes them that much more potent."[9]

Disability

Any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions).[82] Under the traditional medical model, disability was viewed as a problem that exists in a person's body. This has been criticized on several fronts, including for pathologizing and disempowering people with disabilities. In contrast, the social

model of disability focuses on systemic barriers, derogatory attitudes, and social exclusion which require structural solutions, including universal design to meet the needs of all people. "The concept of disability has been used to justify discrimination against other groups by attributing disability to them."[83]

Discrimination

Treatment of an individual or group based on their actual or perceived membership in a social category, usually used to describe unjust or prejudicial treatment on the grounds of race, age, sex, gender, ability, socioeconomic class, immigration status, national origin or religion.[70] Discrimination by default positions some groups to have more advantages, opportunities, resources, protections than others based on a given social characteristic or combination of social characteristics that are differentially valued.

Diversity

Refers to the identities we carry. There are many kinds of diversity, based on race, gender, sexual orientation, class, age, country of origin, education, religion, geography, physical or cognitive abilities, or other characteristics. Valuing diversity means recognizing differences between people, acknowledging that these differences are a valued asset, and striving for diverse representation as a critical step towards equity.[70]

"Discovery" of the Americas

The land known as the Americas was not discovered; it was conquered and appropriated. This violent acquisition and genocide perpetuated by European settlers followed by centuries of ill-informed and harmful federal policy (e.g., boarding schools, urban relocation) by the U.S caused the destruction of many Indigenous peoples' culture and way of life.

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†† Support of Human Rights and Freedom H-65.965

Dominant public narrative

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.

Downstream/upstream

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.

Embodiment

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 mechanisms of disease causation, offering in their place an integrated approach to analyzing the multilevel processes, from societal and ecological to subcellular, that co-produce population distributions of health, disease, and wellbeing."[3]

Environmental justice

Fair treatment and meaningful involvement of all people regardless of race, color, national origin or income, with respect to the development, implementation and enforcement of environmental laws, regulations and policies.

Equity

Refers to fairness and justice and is distinguished from equality. While equality means providing the same to all, equity requires recognizing that we do not all start from the same place because power is unevenly distributed. The process is ongoing, requiring us to identify and overcome uneven distribution of power as well as intentional and unintentional barriers arising from bias or structural root causes.

Ethnicity

Social construct and category based on shared geography, language, ancestry, traditions or history.[86] The boundaries of authenticity (that is, who or what "counts" in recognizing members of an ethnic group) are often changeable and dependent on generational, social, political and historical situations.

Excess deaths

Important metric in social epidemiology to quantify the number of deaths (usually per year) that would not have occurred if the group 1 (e.g., Black) mortality rate equaled that of group 2 (e.g., white).

Exploitation

Systematic transfer of the power of some persons or groups to others. With respect to the working class, it occurs through the social division of labor, specifically "the transfer of the labor of one social group to benefit another … Exploitation enacts a structural relation between social groups. Social rules about what work is, who does what for whom, how work is compensated, and the social process by which the results of work are appropriated operate to enact relations of power and inequity."[87]

Fairness

An important distinction exists between the idea of social justice, which is a standard of rightness, and the idea of fairness, a more limited concept. "Fairness" pays no attention to how power relations in society establish themselves. It primarily emphasizes outcomes within a pre-given set of rules.

"Free" market

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 specifically 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 influence over the infrastructure in which markets operate.

Gay

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]

Gender

Conventionally, refers to the "social, psychological, and emotional traits, attitudes, norms and behaviors, often influenced by society's expectations, that classify someone as man, woman, both, or neither."[36] A term associated primarily with social and cultural differences 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 significant 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 influences 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 affordability, access and use of services and products, and interaction with healthcare providers."[89]

Gender binary

Classification 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.

Gender dysphoria

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

Gender-expansive

A person with a wider, more flexible range of gender identity and/or expression than typically associated with the binary gender system. Often used as an umbrella term when referring to young people still exploring the possibilities of their gender expression and/or gender identity.[76]

Gender expression

"The way in which someone expresses their gender, either consciously or unconsciously. This can encompass everything that communicates our gender to others, including clothing, hairstyle, body language, manner of speaking, social interactions, and gender roles. Most people have some blend of masculine and feminine qualities that comprise their gender expression, and this expression can also vary depending on the social context. There is not always a direct translation between gender identity and gender expression. A person's gender expression may or may not align with the way people attribute gender to that person."[90]

Gender fluid

Term to describe individuals whose gender identity is not fixed, but may change over space, time, context, etc. People who identify as gender fluid may identify outside of the gender binary, e.g., as both male and female or as neither male nor female.

Gender identity

How people conceptualize themselves as gendered beings, including one's innate and personal experience of gender. This may or may not align with one's gender expression or biological sex.

Genderqueer

An umbrella term within the LGBTQ+ community referring to anyone who doesn't prescribe to societal views of gender and sexuality; implies elasticity and a resistance to the notion of a predetermined gender and sexual identity based on biology.

Gender neutral/inclusive pronouns

Pronoun which does not associate a specific binary gender with an individual (e.g., they, them, their, theirs, themself, sie, hir, hirs, hirself, zie, zir, zirs, zirself).

Gender nonbinary

An adjective describing a person who does not identify exclusively or at all as a man or a woman. Nonbinary people may identify as being both a man and a woman, somewhere in between, or as falling completely outside these categories. While many also identify as transgender, not all nonbinary people do. Nonbinary can also be used as an umbrella term encompassing identities such as agender, bigender, genderqueer or gender-fluid.[76]

Gender nonconforming

People who do not follow conventional ideas or stereotypes about gender roles, how they should look or act based on their female or male sex assigned at birth. Can also refer to people who do not identify with their sex assigned at birth.

Gender-inclusive

Term to describe places, spaces, polices, language, procedures, etc., that validate, accommodate and honor the existence, experience, and rights of all gender identities and expressions.

Gender transition or gender confirmation

A process some transgender people undergo to match their gender identity more closely with their outward appearance. This can include changing clothes, names or pronouns to fit their gender identity. It may also include health care needs such as hormones or surgeries.[76] Gender confirmation is the more appropriate term in medical contexts.

Hate crime

Criminal acts, motivated by bias, that target victims based on their perceived membership in a certain social group.

Health care inequities

A measurable, systemic, avoidable and unjust difference in health care access, utilization, quality and outcomes between groups, stemming from differences in levels of social advantage and disadvantage.

Health disparities

Refer to a higher burden of illness, injury, disability or mortality experienced by one group relative to another. In some uses, including in Healthy People 2020, the term is explicitly linked to economic, social or environmental disadvantage but in many cases the term is used to refer to simple mathematical differences (and as such, has fallen out of use in contemporary health equity discourse).[27]

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.

Health equity

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.

Health literacy

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 system. Additionally, Ivelyse Andino has developed an updated term, "healthcare fluency," which offers an equity-focused alternative to health literacy.[94] Health care fluency includes literacy, but also acknowledges the importance of scientific knowledge (i.e., capacity to give true informed consent), cultural perception (i.e., community-level trust in medical system), and confidence (i.e., personal trust in medical system and ability to advocate for self in the medical encounter).

Health inequity

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

Historical trauma

Collective and complex trauma inflicted on a group who share a specific identity or affiliation.[95] It reflects past treatment of certain racial and ethnic groups, especially Native Peoples, including their consignment to reservations with limited resources, and the cumulative harm caused by traumatic experiences and policies. This is another form of structural (i.e., systemic) racism that continues to shape the opportunities, risks and health outcomes of these populations today.[54,96,97] While thinking tends to focus on past treatment, there are modern occurrences that are experienced as collective traumas. The compounding of the old and new traumatic experiences impacts health status and social position today and in the future.

Homophobia

The fear and hatred of or discomfort with people who are attracted to members of the same sex.

Implicit bias

Unconscious mental process that stimulates negative attitudes about people outside one's own "in group" and positive attitude or beliefs about people recognized inside one's own "in group." Implicit racial bias leads to discrimination against people not of one's own group.

Inclusion

Refers to how our defining identities are accepted in the circles that we navigate. Belonging evolves from inclusion; it refers to the extent to which individuals feel they can be authentic selves and can fully participate in all aspects of their lives. Inclusion is a state of being valued, respected and supported. At the same time, inclusion is the process of creating a working culture and environment that recognizes, appreciates, and effectively utilizes the talents, skills and perspectives of every employee; uses employee skills to achieve the agency's objectives and mission; connects each employee to the organization; and encourages collaboration, flexibility and fairness. In total, inclusion is a set of behaviors (culture) that encourages employees to feel valued for their unique qualities and experience a sense of belonging.

Individualism

Philosophy and group of ideas, expressed in symbols, practices, and stories that support the belief that self-sufficient individuals are rational beings who freely make consumer-like choices, independent of political influences, living conditions or historical context. As a philosophy, it problematically obscures the dynamics of group domination.

Intersectionality

Leading feminist and social justice theories and practices acknowledge that intersectionality, first coined by Kimberlé Crenshaw, as legal terminology to recognize the unique experiences and legal challenges of Black women, whom as a group experienced both racism and sexism.[40] It is the ongoing examination of the overlapping systems of oppression and discrimination that communities face based on race, gender, ethnicity, ability, etc. It is our role to continuously examine the multiple forms and kinds of intersectional exclusions. The call for an anti-racist health care system—one which recognizes and addresses the intersectionality of systems of oppression—amplifies every day.[98]

Intersex

Term to describe a subset of individuals whose reproductive organs and anatomy (e.g., primary sex characteristics,

hormones, chromosomes, etc.) do not align with medically defined 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 "differences 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 offensive.

Justice

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.

Latinx

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 specific communities involved in discussion to ask their preference.

Lesbian

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

LGBTQ

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.

Marginalization

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

Medical model of disability

Based on a functional analysis of the body as a machine to be fixed 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 difficult or impossible for individuals with impairments to attain their valued functionings.

Meritocracy

Social system where social advancement is based on one's capabilities and merits rather than family, wealth, or social background and connections. It is also associated with the commonly heard phrase of "pulling yourself up by your bootstraps."

Microaggression

Everyday verbal, nonverbal and environmental slights, snubs or insults, whether intentional or unintentional, which communicate hostile, derogatory or negative messages to persons targeted solely for their membership in historically marginalized groups.

Minority

Term to define the status of a population by what they are not and the lack of some characteristic held by those in the dominant category. Defining people of color as "minorities" is not recommended because of changing demographics and the ways in which it reinforces ideas of inferiority and marginalization of a group of people.[70]

Misogyny

The dictionary definition of misogyny is hatred, contempt for or prejudice against women. However, Kate Manne contends that "it's an ideology founded on controlling and punishing women who challenge patriarchal norms." In her view, misogyny consists of "social systems or environments where women face hostility and hatred because they're women in a man's world—a historical patriarchy."[103]

Narrative change

A long-term strategy towards an end; a tool for restructuring the way people feel, think and respond to the world. Narrative change is concerned with changing perspectives or consciousness, transforming how we communicate. The purpose is to create profound shifts in the narratives, values, beliefs and behaviors of people.

Non-white

Term previously used in the U.S. Census and still heard today to describe people of color. It centers race on whiteness as a norm and implies that those not white are "other." "The moment you say non-white, you have made white people the norm and everyone else a deviation, mutation, or variation of white people and the characteristics associated with whiteness."[104]

Oppression

Unjust or cruel exercise of power or authority; the product of injustice. But also, as Iris Marion Young explains, "… the vast and deep injustices some groups suffer as a consequence of often unconscious assumptions and reactions of well-meaning people in ordinary interactions, media, and cultural stereotypes, and structural features of bureaucratic hierarchies and market mechanisms—in short the normal processes of everyday life."[87]

Outing

Exposing someone's lesbian, gay, bisexual transgender or gender non-binary identity to others without their permission. Outing someone can have serious repercussions on employment, economic stability, personal safety or religious or family situations.[76]

Pansexual

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]

Patriarchy

Systematic domination by men. A system of society or government in which men hold the power and women are largely excluded from it. Male power typically includes political leadership, moral authority, social privilege and control of property. Generates and is supported by hegemonic masculinity.[105]

People of color

Term used mostly, but not exclusively, in the U.S. to describe people not considered "white." The term emphasizes shared experiences of structural racism, and opposes reference to people as "non-white" or "minority." In recent years, the related term BIPOC (Black, Indigenous, and People of Color) has also been used. Not to be confused with the pejorative "colored people". Per Race Forward: "While 'people of color' can be a politically useful term, and describes people with their own attributes (as opposed to what they are not, e.g.: "non-White"), it is also important whenever possible to identify people through their own racial/ethnic group, as each has its own distinct experience and meaning and may be more appropriate."[70]

Person-first language/ people-first language

Emphasizes the individual over the person's condition, e.g., "woman with diabetes," rather than "diabetic woman." In general, public health entities are encouraged to use person-first language whenever possible. However, they should keep in mind that not all individuals prefer person-first language; some, such as the

deaf community, prefer to emphasize their shared group identity as "people who are deaf." It is important to acknowledge that different communities and individuals have different standards and preferences.[106]

Political power

Organized ability to control, exercise, or direct the behavior of people or institutions over time, and influence the outcome of events, as well as the rules that govern the use of power. Sources of power include force, influence, narrative or ideology, and authority, as well as control over resources and wealth. In a society like the United States, it is based on unequal power relations which, whether corporate or governmental, are socially constructed over time and are thus subject to change. Often political power is accepted as legitimate and normal even when the source of power and its processes remain obscure.[107]

Population health

The health outcomes of a group of individuals, including the distribution of such outcomes within the group. The field of population health includes health outcomes, patterns of health determinants, and policies and interventions that link them.[108,109]

Post-racial society

Term used to describe a time in which racial prejudice and discrimination no longer exist. The term based on the assumption, says Ta-Nehisi Coates, "that the long struggle that commenced when the first enslaved African arrived on American soil centuries ago could somehow be resolved in an instant." He adds: "America's struggle is to become not post-racial, but post-racist. Put differently, we should seek not a world where the black race and the white race live in harmony, but a world in which the terms black and white have no real political meaning."[110]

Powerlessness

Realizing health equity depends on being able to influence, shape, and secure healthy living and working conditions by participation in decision-making affecting 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.

Prevention/preventive medicine

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.

Privilege

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

Public health

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 definition, 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 efforts 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 field 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-profit organizations. In some ways public health includes an interdisciplinary range of activities since all realms of economic and social life play a role in affecting health outcomes, particularly health inequities.

Public narrative

Collection of stories or explanations that reflect 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 refined 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

mosaics, stories are to narratives. The relationship is symbiotic; stories bring narratives to life by making them relatable and accessible, while narratives infuse stories with deeper meaning."[9]

Queer

A term people often use to express a spectrum of identities and orientations that are counter to the mainstream. Queer is often used as a catch-all to include many people, including those who do not identify as exclusively straight and/or folks who have non-binary or gender-expansive identities. This term was previously used as a slur (and is still considered a slur by some) but has been reclaimed by many parts of the LGBTQ+ movement.[76]

Questioning

A term used to describe people who are in the process of exploring their sexual orientation or gender identity.[76]

Race

System of categorizing people that arises to differentiate groups of people in hierarchies to advantage some and disadvantage others. Stated another way, race is a social construct or "a symbolic category [actively created and recreated, rather than pre-given], based on phenotype or ancestry and constructed to specific racial and historical contexts, that is misrecognized as a natural category."[114] While often assumed to be a biological classification, based on physical and genetic variation, racial categories do not have a scientific basis.[70]

Camara Jones explains: "the variable race is only a rough proxy for socioeconomic status, culture, and genes, but it precisely captures the social classification of people in a race-conscious society such as the United States. The race noted on a health form is the same race noted by a sales clerk, a police officer, or a judge, and this

racial classification has a profound impact on daily life experience in this country. That is, the variable 'race' is not a biological construct that reflects innate differences, but a social construct that precisely captures the impacts of racism."[45]

Race is a concept forged by oppressive systems of race relations, justified by ideology, in which one group benefits from dominating other groups, and defines itself and others through this domination and the possession of selective and arbitrary physical characteristics (for example, skin color).[115] Race, more perniciously, is a political construction created to concentrate power with white people and legitimize dominance over non-white people.[53,116]

Racialization

The imposition, over time, of racial differences onto a population. This process or set of processes may or may not be animated by conscious forces, rather than a static event that constructs races as real and unequal that negatively affects social, economic and political life. It underscores the fluid and dynamic nature of race.[117] Racialization can also be described as a form of judgmental racial classification characterizing a population group which is used, publicly, to justify stigmatization, exploitation and paternalism.[118]

Racial capitalism

Idea that racialized exploitation and capital accumulation are mutually reinforcing.[119] The concept is attributed to Cedric Robinson, who argued that "the development, organization and expansion of capitalist society pursued essentially racial directions."[120]

Racial domination

"A type of power that encompasses the *symbolic* power to classify one group of people as 'normal' and other groups of

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 life; and the *economic* power that privileges Whites in terms of job placement, advancement, wealth, and property accumulation."[114]

Racial justice

The systematic fair treatment of people of all races, resulting in equitable opportunities and outcomes for all. Racial justice—or racial equity—goes beyond "anti-racism." It is not just the absence of discrimination and inequities, but also the presence of deliberate systems and supports to achieve and sustain racial equity through proactive and preventative measures.[70]

Racism

As defined by Camara Jones, "racism is a system of structuring opportunity and assigning value based on phenotype ("race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources"[121] Racism can operate at different levels: structural, institutional, interpersonal and internalized.

- **Structural**
  As defined by Zinzi Bailey et al, structural racism "refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources."[7] Structural racism results in systemic variation in opportunity according to race or ethnic

background—including differentials in access to health care based on race.[7,14,54] It is a deep-seated and core form of social injustice and oppression seen across society, perpetuating cumulative advantage for whites throughout life.

- **Institutional**
  Discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race. Individuals within institutions take on the power of the institution when they act in ways that advantage and disadvantage people, based on race.

- **Interpersonal**
  The expression of racism between individuals. These are interactions occurring between individuals that often take place in the form of harassing, racial slurs or racial jokes. It may also take more subtle forms of unequal treatment, including micro-aggressions.

- **Internalized**
  Acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth.[45]

Racial essentialism

A belief in a genetic or biological basis for categorization that defines membership of a racial category. Underpinning the belief are notions of *naturalness* (e.g., "race" is a natural/objective category rather than a social construction), *cross-cultural stability* (e.g., racial categories hold the same meaning across the world), and *inductive potential* (e.g., knowledge of a person's race can inform your actions and decisions pertaining to that person).[122]

Racial exploitation

Racial exploitation has been a common form of discrimination‡‡ in not only the undemocratic workplace itself through

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‡‡ Equal Opportunity H-65.968

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 effects on health outcomes.

Root causes

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.

Section 503 and 508

Section 503 of the Rehabilitation Act of 1973 is a law that prohibits federal contractors and subcontractors from discriminating in employment against individuals with disabilities and requires employers take affirmative action to recruit, hire, promote and retain these individuals. Section 508 requires that the federal government procure, create, use, and maintain information and communications technology that is accessible to people with disabilities, regardless of whether or not they work for the federal government.

Sex assigned at birth

A concept used to describe a person's sex assigned at birth, typically based on a subjective evaluation of external anatomic structure(s) and its comparison to various sex categories. This may or may not align with how they identify themselves.

Sexism

Discrimination based on sex, typically the belief that cisgender males are inherently superior to all other genders.

Sexual orientation

An inherent or immutable enduring emotional, romantic or sexual attraction to other people. Note: an individual's sexual orientation is independent of their gender identity.

Social determinants of health

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

Social determinants of health inequities

Refer to the connection between social determinants of health (SDoH) *and* place-specific levels of health inequities. This acknowledges that while underlying community-wide social, economic and physical conditions in which people are born, grow, live, work and age affect individual level health they also influence patterns of health inequities within and between communities.[123]

Social drivers (of health)

An umbrella term to refer to social needs *and* social determinants of health inequities.

Social epidemiology

The branch of epidemiology that focuses on the effects of social-structural drivers of health.

Social exclusion

Relational process of denying groups of people access to economic social political and cultural resources, based on unequal power relations. Experienced most vividly in housing and employment as well as

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

Social gradient of health

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]

Social justice

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.

Social model of disability

Focuses on systemic barriers, derogatory attitudes, and social exclusion (intentional or inadvertent), which make it difficult 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 fixed 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 affect 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]

Social needs

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 specific adverse social conditions that are associated with poor health, including social isolation, food insecurity or housing instability.[127]

Stereotype

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 "othering" groups and denying people their individuality, culture and humanity.

Stigma

Elements of labeling, stereotyping, separating, status loss and discrimination[§§] co-occurring in a power situation that allows these processes to unfold.[128]

Stigmatizing language[¶¶]

According to Mona Shattell, "Language is a method of communication that transmits intended and unintended meanings. Unintended stigmatizing meanings, which are probably more insidious and dangerous (than language that clearly communicates intended meanings) can perpetuate socially constructed power dynamics and become so 'commonplace' that they are invisible. Persons must be aware of these unintended stigmatizing meanings. … Stigmatizing language with unintended meanings can perpetuate power and control and further marginalize persons … [or communities]."[129] Stigmatizing

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§§   Support of Human Rights and Freedom H-65.965
¶¶   An example of an AMA policy in support of person-first language: Person-First Language for Obesity H-440.821

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

Structural competency

According to Jonathan Metzl and Helena Hansen, "the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g., depression, hypertension, obesity, smoking, medication "non-compliance," trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health. … [It] consists of training in five core competencies: (1) recognizing the structures that shape clinical interactions; (2) developing an extra-clinical language of structure; (3) rearticulating 'cultural' formulations in structural terms; (4) observing and imagining structural interventions; and (5) developing structural humility."[22]

Structural determinants of health equity

Described by social epidemiologist Nancy Krieger as directly connected to social injustice; "political-economic systems, whereby health inequities result from the promotion of the political and economic interests of those with power and privilege (within and across countries) against the rest, and whose wealth and better health is gained at the expense of those whom they subject to adverse living and working conditions."[3]

Structural violence

A term first developed by Johan Galtung to describe violence (harm) generated by a society's system of stratification. According to Galtung: "If a person died from tuberculosis in the eighteenth century, it would be hard to conceive of this as violence since it might have been quite unavoidable, but if he dies from it today, despite all the medical resources in the world, then violence is present."[130] For Galtung, structural violence is synonymous with social injustice. The term has been popularized in health equity work by Paul Famer et al., who define structural violence as "social arrangements that put individuals and populations in harm's way. The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people."[131] The concept's power lies in its focus on the deep structural roots of health inequities; in contrast to the more passive term "social determinants of health," structural violence explicitly identifies social, economic and political systems as the causes of the causes of poor health.[132]

Structural vulnerability

Term developed by Philippe Bourgois, Seth Holmes, and others to describe an individual's or a group's condition of being at risk for poor health outcomes through their interface with socioeconomic, political, and cultural/normative hierarchies.[133,134] Patients are structurally vulnerable when their location in their society's multiple overlapping and mutually reinforcing power hierarchies and institutional and policy-level statuses constrain their ability to access health care and make healthy choices.[41]

Transgender/transsexual/trans

Denotes a person whose sense of personal identity and gender expression does not correspond with their assigned sex at birth. Some people who request medical and/or surgical assistance to transition from one sex to another identify themselves as transsexual. Many transgender people experience extensive forms of discrimination*** by the medical

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*** Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation

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 significant health disparities such as a disproportionately higher burden of mental health illness, including increased rates of depression, anxiety and suicide.[135]

Two-spirit

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 fulfill 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 between Indigenous groups.[136] It is also not a term that can be used by a non-Indigenous person.[136]

WCAG (Web Content Accessibility Guidelines)

Formalized standards by law as of 2017, with requirements starting January 2018 for all government contractors to make their electronic and information technology (EIT) compliant to be considered accessible.

Weathering

A hypothesis first proposed by Arlene Geronimus positing that Blacks experience early health deterioration as a consequence of the cumulative impact of repeated experience with social or economic adversity and political marginalization.[137] The hypothesis has been explored with other groups, including American Indian and Alaska Native elders, documenting the structural roots of weathering.[138]

White fragility

According to Robin DiAngelo, "White fragility is a state in which even a minimum amount of racial stress becomes intolerable, triggering a range of defensive moves. These moves include the outward display of emotions such as anger, fear and guilt, and behaviors such as argumentation, silence and leaving the stress-inducing situation. These behaviors, in turn, function to reinstate white racial equilibrium. Racial stress results from an interruption to what is racially familiar."[139] For Katy Waldman, it is "the disbelieving defensiveness that white people exhibit when their ideas about race and racism are challenged—and particularly when they feel implicated in white supremacy."[140]

White privilege

Unquestioned and unearned sets of advantages, entitlements, benefits and options that people have solely because they are white. Generally, white people who experience such privilege do so without being conscious of it.

White supremacy

Historically based, institutionally perpetuated system of exploitation and oppression of continents, nations, and people of color by white people and nations of European descent for the purpose of maintaining and defending a system of wealth, power and privilege.

"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 affirming 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.

Whiteness

It is important to differentiate "white" (a category of racial classification with no scientific basis) and "whiteness" (reflecting the power and privileges that people who are defined 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 significance, 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 exemplified 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 efforts 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.

We extend deep gratitude to the many contributors and reviewers who helped to create this document.

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