Central Oregon Diversity Equity and Inclusion (CODEI) Committee

February 1, 2023; 8:30am – 10:00am

Join by computer: https://us02web.zoom.us/j/83986249949?pwd=WkQ5MmpiRk12U1JpL2J4WS9iUmFSZz09
Join by phone: 1 253 215 8782 or 1 669 900 6833
Meeting ID: 839 8624 9949
Passcode: 305212

8:30 am - 8:50 am Welcome, Guiding Principles, Introductions
• Relationship Building and Learning Conversation: Black History Month

8:50 am –9:00 am Context setting for 2023-COHC updates
• RHA Community health survey
• CHOC Advocacy Scope update

9:00am -10:00 am CODEI Action Plan.
• CODEI Policies and Practices Equity Review
  o CODEI Charter Consensus Workshop Feb

Links to Shared Documents
COHC Webpage:
https://cohealthcouncil.org/

Shared Google Drive:
https://drive.google.com/drive/folders/1Y3-hzNmUV9aZ5rXh9iORVtA4jPp87U2N?usp=sharing

Regional Health Improvement Currently Funded Projects:
https://www.centraloregonhealthdata.org/tiles/index/display?id=254047713344660685

Next Meeting –Next Meeting will be on March 1, 2023; 8:30am
Land Acknowledgment

We recognize and acknowledge the indigenous land on which we live, work, learn, play, and grow. This is the land of the Warm Springs, Wasco, Northern Paiute, Tenino, Klamath, Molalla, and Yahooskin. We acknowledge them as the past, present, and future caretakers of this land. It is on their traditional land that we partner to improve the health and well-being of Central Oregonians. We aspire to be good guests honoring the concept in the Warm Springs culture: “This land is for you to know and live upon and pass on to the children.”

Central Oregon Diversity, Equity and Inclusion Committee

Central Oregon Health Council Committee
As the Central Oregon Diversity, Inclusion and Equity Committee we collectively and individually practice and believe in:

- **Solidarity**
  - We move toward action in solidarity with our neighbors to actively and positively impact our agencies and communities.

- **Humility**
  - We carry the burden of history and a better future together, responsible to each other and ourselves for the space and energy we give and take.

- **Curiosity**
  - The direction we seek is bigger than any one of ourselves or agencies. We actively work to see a broader perspective, gain deeper insight, self-reflect and work towards equitable representation of diverse identities.

- **Courage**
  - This is courageous work. We choose to lean into the discomfort we experience knowing we grow in understanding and relationships.

- **Transformation**
  - Our lived experiences and need for safety are as true and diverse as we are. It is through invitation, curiosity, and listening that we reach our greatest shared understanding and commitment to transformative action.
CODEI Charter

Consensus Workshop
Workshop Question

What will we explore together today?

What are the purpose and responsibilities of (a successful) CODEI?
Group 1 - Ana, Carmen, Liliana, John, Karen, Mary Ann

What are the purpose and responsibilities of (a successful) CODEI?

Our 10-15 ideas:

- advocate for clients
- **clarity of roles of CODEI members**
- putting into practice what’s being learned
- Confidentiality
- Communication
- building a process for accountability to others
- taking actionable steps
- growth mindset
- Improve access for care
- improving health care experiences
- authority to be more robust
- Representation; who is invested
- Governance and authority
- **intentional strategy**
- Funding
- POLICY
- advise on state and regional funding for diversity and cultural impact needs
- Value and mission statements for CODEI

Use this space to keep additional notes if needed!

- Governance and authority
- Advise on state and regional funding for diversity and cultural impact needs
- Funding
Group 2 - Kat, Kimberly, Miguel, Shimiko, Noura

What are the purpose and responsibilities of (a successful) CODEI?

Our 10-15 ideas:

- Identify areas that need funding
- Increase access/Make it easier to navigate HC
- Increase impact of CODEI
- Advocate for policy changes
- DEI in healthcare – who is who
- Identify areas that need improvement
- Fund areas that need improvement
- Impact policy in health council
- Contaminate the other workgroups and committees with social justice and equity
- Support Regional Health Assessment (RHA)
- Build trust so members aren’t always changing
- Resource and empower impacted communities
- Evaluate progress
- Dismantle oppressive systems and create new ones
- Help identify where to provide support and/or funding
- Include time frame for charter review process
The purpose and responsibilities of a successful CODEI are...

- **Representation (Inclusion, Respect, Participation)**
  - Communication-intentionality of language and audience
  - Representation & who is invested
  - Build trust so members aren’t always changing / DEI in healthcare - who is who

- **Structure/authority**
  - Governance - delegates the authority to ensure DEI to the CODEI workgroup
  - Authority - expertise/knowledge of each member
  - Authority - council/larger group
  - Authority to be more robust
  - clarity of roles of CODEI members
  - Include time frame for charter review process

- **Community advocacy and empowerment**
  - Improve access for care and experiences
  - Advocate for clients
  - Increase access/Make it easier to navigate HC
  - advocate for policy changes
  - Resource and empower impacted communities
  - Empowering community members

- **Elevating Social Justice**
  - Contaminate the other workgroups and committees with social justice and equity
  - Increase impact of CODEI through policy changes
  - putting into practice what’s being learned
  - Dismantle oppressive systems and create new ones
  - Building the cause

- **Funding**
  - Advise on state and regional funding for diversity and cultural impact needs
  - Funding
  - identify areas that need funding
  - fund areas that need improvement

- **Accountability & Evaluation**
  - Building a process for accountability
  - Evaluating progress on equity topics
  - intentional strategy
  - Confidentiality
  - Continuing education (internal member)
The purpose and responsibilities of a successful CODEI are...

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- **Community advocacy and empowerment**
  - Improve access for care and experiences
  - Advocate for clients
  - Increase access/Mak[...](RHA)

- **Funding**
  - Advise on state and regional funding for diversity and cultural impact needs
  - Funding
  - Identify areas that need funding
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The purpose and responsibilities of a successful CODEI are...

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  - Building a process for accountability
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  - Confidentiality
  - Continuing education (internal member)
  - Continuing education (community)
The purpose and responsibilities of a successful CODEI are...

Our next steps in developing a proposed revised CODEI Charter:
Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity
2021–2023
AMA and equity—an historical record

Acknowledging our historical harms (1847–1997)

“But all our phrasing—race relations, racial chasm, racial justice, racial profiling, white privilege, even white supremacy—serves to obscure that racism is a visceral experience, that it dislodges brains, blocks airways, rips muscle, extracts organs, cracks bones, breaks teeth. You must never look away from this. You must always remember that the sociology, the history, the economics, the graphs, the charts, the regressions all land, with great violence, UPON THE BODY.”

—Ta-Nehisi Coates, author and journalist, *Between the World and Me*

No set of organization-wide commitments to embedding equity and anti-racism can succeed without first initiating an honest accounting of our AMA’s past and/or persistent practices that excluded, formally or informally, physicians based on race, ethnicity, gender, sexual orientation, ability and country of origin (i.e., International Medical Graduates), and caused long-standing harm to historically marginalized and minoritized communities. Historically, AMA policies have not always been well-aligned with an equity and justice imperative.

We cannot deny that AMA’s past silence on certain health system and policy-related issues has contributed to and had a negative impact on historically marginalized and minoritized communities, and exclusion in medicine more broadly. Furthermore, we recognize the longstanding archival silence that has occurred at the AMA. Archival
silence is the unintentional or purposeful absence or distortion of documentation of enduring value, resulting in gaps and inabilities to represent the past accurately.

Our equity agenda is also reconciliatory. Some health policies have been a critical vehicle, driving inequity in terms of health care access, quality and safety of care delivery, and with respect to distribution of non-medical resources pertinent to other public policy leading to disparate impact on historically minoritized and marginalized communities’ ability to achieve optimal health.

While not exhaustive, the following illustrates some of the legacy of such harmful practices or proceedings:

- AMA Transactions published the requirements to practice medicine in the states: In 1849, one of the state medical societies called for all “irregular-bred pretenders,” like “Indian Doctors,” to be considered illegal practitioners. Though this is a state society policy and not AMA policy, we published this in our official records without question or commentary.49 (p. 327)

- In 1871, the official positioning of the President of the AMA, Wilfred Stille, MD, during a formal address to assembled membership, asserted that women are inferior to men in all respects, even though some may technically be qualified as physicians. Stille argued the “woman question” (whether women should be allowed in any field) is a distraction and infects everything in this time period. He said, it “raves at political meetings, harangues in the lecture-room, infects the masses with its poison, and even pierces the triple brass that surrounds the politician’s heart.”50 Stille also argued that women may be able to care for others, but their nature (as women) inherently prevents them from achieving the powers of intellect and discernment necessary for physicians. “The laws of nature are eternal and immutable. The law which makes man the father and woman the mother of children impresses upon both [men and women] characters which are inseparable from their functions and determine their relative positions in the world; gives government to the one and subordination to the other; to the one intellect, to the other heart.”51

- In 1876, J. Marion Sims served as president of the AMA. Long heralded as the “father of modern gynecology,” the historical record clearly shows that his renowned medical innovations were developed through countless rounds of non-anesthetized vaginal surgical experimentation. Sims’s procedures, upon women who were enslaved—at least three of whom were named Lucy, Anarcha and Betsey, as documented in his own autobiography. His procedures catapulted him to fame and influence early in his career. His work caused immeasurable suffering on his “subjects” and reinforced essentially racist misconceptions in medical science, specifically regarding the biological differences of feeling pain between Blacks and whites that still persist to this date.
From the 1870s through the early 19th Century, two Washington, D.C., medical societies sent rival delegations to the AMA’s national meetings: an all-white delegation from one medical society and an integrated delegation from a medical society led by physicians from Howard University. The integrated delegation was twice excluded from the meetings of the AMA House of Delegates, while the all-white society’s delegates were admitted. AMA leaders voted to devolve the power to select delegates to individual state societies, thereby tacitly accepting racial segregation of constituent societies. This eventually forced African American physicians to create their own organizations, including the National Medical Association in 1895. AMA’s decision 25 years before *Plessy v Ferguson*, made the association a model of how to accomplish racial segregation in a national organization by allowing racial segregation decisions to devolve to local components.

The National Medical Association was steadfast in its attempts to persuade the AMA to take action against racially discriminatory membership practices throughout its constituent state and county societies. Exclusion from AMA membership created direct barriers to specialty training and professional development for Black physicians, directly harming minoritized communities who suffered from a dearth of access to qualified physicians. For example, in 1931, there were 25,000 subspecialty trained physicians in the United States, and only two of them were Black: Daniel Hale Williams, MD, and William Harry Barnes, MD.

In 1901, the *Journal of the American Medical Association* (*JAMA*) published an article supporting The Chinese Exclusion Act. “The Chinese Exclusion Act is to be up before the coming Congress, and for sanitary reasons it is to be hoped that it will be re-enacted.” Rationale for this included that “we have to protect ourselves. That this is a Christian country, and we regard them as heathen, should not make us altruistic to our harm.”

The AMA-supported Flexner Report (1910) issued critical recommendations, which transformed medical education, and conferred guidelines that determined the closure of all but three women-only medical schools and two African American medical schools across the nation. Consequently, the Flexner Report cemented in place a Black medical education and health care delivery system that was separate, unequal, under-resourced, and destined to be insufficient to meet the needs of African Americans, nationwide. For women, this also had a devastating impact. In 1915, 2.9 percent of medical school graduates were women. By 1930, only one women-only medical school remained. The enrollment trend rate for women remained under 5 percent until the 1970s.

As far back as the 1840s, there were several references in AMA documents to diseases attributed to “Jew peddlers.” Jews at one point in history were racially categorized as non-white until the mid-1930s and were categorized as white. And it is also well known that one of the many indirect results of the Flexner Report was a tightening of medical school admissions, which led to quotas on how many Jews could attend. Morris Fishbein, MD, editor of *JAMA* at the time, admitted in 1939 that Jewish boys applying to medical schools were turned down, “simply because they were Jewish,” but he justified this on the basis that they already represented 15 to 20 percent of American doctors.

Beginning in 1906, our AMA’s American Medical Directory, which lists all U.S. physicians, officially marked African American doctors with the notation for “colored.”
• In 1939, the AMA appointed a committee to consider “the welfare of colored physicians.” While the AMA decried racial discrimination in state and local society membership, it concluded that every “medical society has the right of self-governance” in membership. Such a contradictory stance rendered moot the intended impact of its overall declaration.

• Between 1940 to 1964, many attempts to change discriminatory AMA membership policies and practices were rejected by the AMA House of Delegates. For example, in 1944, NMA members requested “associate membership” in the AMA—the AMA expressly denied this request. Nearly 20 years later, in 1963, another policy proposal was presented. This time it called for the exclusion of state societies that touted discriminatory membership policies—this, too, AMA leadership and delegates rejected.

• During the 1960s Civil Rights era, in spite of being petitioned by the Medical Committee for Civil Rights to (i) admonish segregationist practices in health care systems to shut down any society which operated by racial exclusionary practices; (ii) oppose the 1946 Hill-Burton “separate but equal” Act; and (iii) oppose accreditation or reaccreditation of non-integrated hospitals, our AMA did not support any of these efforts, nor did our AMA support African American physicians who fought for legal remedies to hospital segregation.

We recognize these events as pivotal watershed moments affecting many historically marginalized and minoritized groups, not all, and primarily race-based, and acknowledge these are not exhaustive of all the ways in which the AMA may have contributed to health inequities and are perpetuating harms, even to this day. (Please see Appendix #9 for more in-depth overview of past AMA harms to different marginalized and minoritized communities and/or physician groups.) As we set out, our organizational strategy to drive medicine forward with an equity lens, we must excavate and re-examine our deep past so as not to make the same, or like, grave, tragic and deadly errors. This work is extensive, and we remain committed to uncovering the harm done to marginalized groups. Let us be clear that harms to historically marginalized and minoritized groups do not exist in a time capsule and persist to this date.

Therefore, in parallel, we are working extensively to name and reconcile present day harms caused by AMA policies and actions.