

AORN Position Statement on Health Care Equity and Racial Justice

POSITION STATEMENT

AORN believes:

- All patients have the right to receive the highest quality perioperative care in every practice setting where operative and other invasive procedures are performed.¹
- There is well-documented evidence of widespread disparities in health care among historically **marginalized patients**, including differences that have been associated with poor surgical outcomes.
- **Profiling**, **bigotry**, or intentions to treat patients differently based on their personal attributes have no place in health care.

RATIONALE

In 2003, the Institute of Medicine, now known as the National Academy of Medicine, defined disparities in health care as “racial or ethnic differences in the quality of health care that are not due to access related factors or clinical needs or preferences or appropriateness of interventions.”² Although a diverse range of factors contribute to the issue – from the blatant racism of stereotyping, bias, and prejudice to clinical uncertainty on the part of health care providers – the fact remains that disparities significantly and negatively impact historically marginalized patients. Health care providers, institutions, professional organizations, patient representatives, and all stakeholders invested in the health and well-being of our diverse patient population must collaborate to create and maintain a systematic and fundamental change to ensure **equity** in all aspects of care for all patients.

As a leader in safe patient care, AORN is committed to taking a proactive approach to improving surgical outcomes for all patients and providing more equitable health care, not only to fulfill the organization’s core mission, but also because these disparities are symptoms of a larger, more insidious problem the organization is committed to fighting. Disparities in health care are a part of systemic racism and prejudice that permeates every facet of our society in myriad direct and indirect ways. As AORN noted in an open letter to its staff and the perioperative community following George Floyd’s death, “all racism is unacceptable.” AORN went on to state, “we demand of our employees and ask the perioperative community to commit to zero tolerance for any racist acts and injustice” (AORN, Inc, email communication, June 5, 2020).

Disparities in health care and less-favorable surgical outcomes are examples of injustice, and AORN supports the development of collaborative, comprehensive initiatives to promote policy, practice, and research that aim to make health care equity a strategic priority for all health care providers, institutions, and professional organizations. Disparities in equitable health care are common, and a surge in new research on **diversity**, equity, and **inclusion** (DEI) only confirms what we already know: a multitude of factors including, but not limited to, **race**, nationality, **ethnicity**, **culture**, **sexual orientation**, **gender**, **gender identity**, age, education, mental illness, physical abilities or disabilities, **socioeconomic background**, **spirituality**, and personal beliefs can have a profound effect on a patients’ ability to receive

equitable health care. Therefore, in our role as patient advocates, it is the responsibility of AORN – and its members – to understand the systemic issues behind these health care disparities and then work to improve and eradicate them.

AORN recommends that all health care personnel and stakeholders take extraordinary action in their own practices to diminish and ultimately eliminate all disparities present within current models of care. Perioperative nurses are obligated to provide safe, professional, and ethical patient care, as defined by the AORN Perioperative Explications for the *ANA Code of Ethics for Nurses*.³ Extensive interventions are necessary to correct the inequity in current care delivery systems. We must all take action in our personal and professional development and practice to understand and learn from the mistakes of our society's past and ensure every patient's treatment is guided by the same ethical and moral standards to achieve quality patient care and favorable outcomes for all.³

Actions and recommendations to facilitate this change include the following:

Individual and Workplace Actions

- Make health care equity a personal and organizational priority.⁴
- Promote awareness and action that leads to meaningful and sustainable changes. To progress toward equitable treatment, we must identify and confront the discriminatory practices and policies that have plagued our abilities to correct injustices.⁵
- Promote workforce diversity and leadership development opportunities for minorities. Diversity of the health care workforce has strong associations with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, improved communication between patients and providers, and better educational experiences for health care professionals. Evidence suggests that a more diverse workforce can improve cultural competence of both health professionals and health systems, which can, in turn, create improvements in patient outcomes.⁶⁻⁸
- Create evaluation measures and metrics that assess the contribution of workforce diversity to eliminating **health disparities**.⁷
- Use evidence-based guidelines to support consistency and equity of care.²
- Ensure that adequate means of patient-provider communication are available and used when barriers to communication exist.²

Workforce Education

- Develop new educational curricula to teach ways to counteract the effects that nonmedical factors have on clinical decision-making processes and strategies, to promote effective communication with patients of diverse sociocultural backgrounds.^{7,9,10}
- Include DEI content in annual education and new hire orientation of perioperative personnel. In a comprehensive review of the literature on **implicit bias** in health care professionals, FitzGerald and Hurst¹¹ found that the same systemic biases exist among the medical community as are seen in the general public. Understanding one's own implicit bias and its effect on care delivery is a critical step for providers to take to provide the high quality of care that all patients deserve.¹²

Health Care Reform

- Promote DEI research. Collect and report data on health care access and utilization by patients' race, nationality, ethnicity, culture, sexual orientation, gender, gender identity, age, education, socioeconomic background, spirituality, and personal beliefs.²
- Include measures of racial, ethnic, socioeconomic, language, gender, gender identity, and sexual orientation disparities in performance measurements.²
- Improve the number and capacity of diverse providers in underserved communities.^{2,6}
- Establish effective preventive care models.²
- Optimize patient care through the use of interdisciplinary teams, including but not limited to, physicians, nurses, dietitians, and social workers. Research indicates that interdisciplinary care teams are effective in improving health outcomes of minorities through streamlining care, promoting adherence to follow-up care, and managing behavioral and social risks faced by patients.²
- Deploy strategies to address the multiple **social determinants of health** on which health care stakeholders can have a direct impact.^{4,10}
- Expand health coverage and access to federal and state insurance programs for the underinsured and the uninsured.¹⁰
- Promote flexible bill payment structures.²
- Identify and retire provider incentives that inadvertently promote disparities or marginalization of patients.²

GLOSSARY

Bigotry: Prejudice and/or discrimination against a person or group based on stereotypes.¹³

Culture: Integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.¹⁴

Diversity: “The presence of differences that may include race, gender, religion, sexual orientation, ethnicity, nationality, socioeconomic status, language, (dis)ability, age, religious commitment, or political perspective. Populations that have been – and remain – underrepresented among practitioners in the field and marginalized in the broader society.”¹⁵

Equity: “Promoting justice, impartiality and fairness within the procedures, processes, and distribution of resources by institutions or systems. Tackling equity issues requires an understanding of the root causes of outcome disparities within our society.”¹⁵

Ethnicity: Refers to the shared social, cultural, and historical experiences, stemming from common national or regional backgrounds, that make subgroups of a population different from one another.¹⁶

Gender: The characteristics and roles of women and men according to social norms. While sex is described as female, male, and intersex, gender can be described in terms such as feminine, masculine, and androgynous.¹⁷

Gender expression: The ways in which we present ourselves to others, such as through mannerisms, clothing, body language, and hairstyles.¹⁸

Gender identity: Our inner sense of being a man, woman, or another gender.¹⁸

Health disparity: “A particular type of health difference that is closely linked with social or economic disadvantage.”¹⁹

Implicit bias: The attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner.²⁰ Synonym: Unconscious bias.

Inclusion: “An outcome to ensure those that are diverse actually feel and/or are welcomed. Inclusion outcomes are met when you, your institution, and your program are truly inviting to all. The degree to which diverse individuals are able to participate fully in the decision-making processes and development opportunities within an organization or group.”¹⁵

Marginalized patients: Groups and communities that historically experience discrimination and exclusion (ie, social, political, economic) because of unequal power relationships across economic, political, social, and cultural dimensions.²¹

Profiling: The practice of extrapolating information about a person based on known or perceived traits or tendencies.²²

Race: A subjective social construct based on observed or ascribed characteristics that have acquired socially significance.²³

Racism: Assaults on the human spirit in the form of biases, prejudices, and an ideology of superiority that persistently cause moral suffering and perpetuate injustices and inequities.²⁴

Sexual orientation: How a person characterizes their sexual attraction to others.¹⁸

Social determinants of health: Factors in the environment including where people live, learn, work, and play that impact their ability to make healthy decisions.¹⁹

Socioeconomic background: The social standing or class of an individual or group, often measured as a combination of education, income, and occupation.²⁵

Spirituality: Having to do with deep, often religious, feelings and beliefs, including a person’s sense of peace, purpose, and connection to others, and beliefs about the meaning of life.²⁶

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RESOURCE

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