MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution: 2017 - 165

Introduced by: MSSNY Medical Student Section

Subject: Development and Utilization of Clinical Decision Support Systems to Reduce Gender Disparities and Bias in Healthcare

Referred to: Reference Committee on Public Health and Education

Whereas, numerous studies have demonstrated the widespread existence of gender bias and disparities in the provision of health care; and

Whereas, it has been shown that women wait longer to receive cardiac-related diagnostic testing and care than men and are less likely than men to undergo cardiac-related treatment at all;\(^1,2,3\) and

Whereas, studies have shown significantly increased in-hospital deaths after myocardial infarctions in female patients, as compared with male patients;\(^4\) and

Whereas, there is evidence that female patients receive consistently less intensive treatment for acute myocardial infarction;\(^5\) and

Whereas, differences in mortality outcomes and provision of critical care have been found between men and women of similar age;\(^6\) and

Whereas, there exist gender disparities in referral patterns and wait times for orthopedic surgery, with evidence of women waiting longer for surgery from time of injury (20 vs. 14 months);\(^7\) and having worse pain and disability at the time of surgery;\(^8\) and

Whereas, the probability of developing somatoform or anxiety disorders is greater in women than in men and may therefore be falsely attributed to the cause of pain or illness in women, and that a gender-biased misdiagnosis may increase a patient’s anxiety and distress about an illness and further influence an incorrect somatoform or anxiety diagnosis;\(^9,10\) and

Whereas, it has been shown that patients with a feminine gender identity or presentation are at risk for gender-bias in health care regardless of biological sex;\(^11\) and

Whereas, it has been demonstrated that awareness of gender bias does not negate its effect;\(^12\) and

Whereas, it has been demonstrated that clinical decision support (CDS) systems are effective tools in diagnosis, management of disease, and improving patient safety;\(^13\) and

Whereas, a checklist CDS system has proven effective in reducing the rate of complications and mortality in surgical procedures;\(^14\) and

Whereas, prior to utilizing a CDS tool female trauma patients were prescribed appropriate venous thromboembolism (VTE) prophylaxis significantly less often than male patients (55.1% vs. 69.5%);\(^15\) and
Whereas, utilization of CDS increased prescription of VTE prophylaxis (from 76.4% to 95.6%) and completely eliminated the incidence of preventable VTE at Johns Hopkins Hospital;\textsuperscript{12} and

Whereas, CDS has been shown to eliminate significant differences in the appropriate prescription of VTE prophylaxis prescription for male (85.7%) and female (81.2%) patients;\textsuperscript{11} and

Whereas, it has been shown that an appropriate CDS tool is capable of reducing health care gender disparities through the reduction of gender bias;\textsuperscript{11} and

Whereas, the Commission to End Health Care Disparities seeks to ensure equitable, appropriate, effective, safe, and high quality care for all, with no gaps in services based on any medically irrelevant factor;\textsuperscript{13} and

Whereas the World Health Organization Commission on the Determinants of Health observed that taking action to improve gender equity in health [é ] is one of the most direct and potent ways to reduce health inequities and ensure effective use of health resources;\textsuperscript{13} and

Whereas, the American Medical Association has existing policy declaring a commitment to eliminating healthcare disparities with a specific mention of racial and ethnic health disparities,\textsuperscript{13} but does not have a policy directly targeting gender-based health care disparities; and

Whereas, MSSNY has stated positions supporting the provision of equal health care and elimination of disparities in healthcare based on sex and gender identity, as well as a position to use EMR to prompt physicians about gaps in care of their patients and also help with clinical decision support;\textsuperscript{13} therefore be it

RESOLVED, that the MSSNY will support the development and implementation of clinical decision support systems designed to mitigate gender bias in diagnosis and treatment of conditions in which gender disparities are prevalent.

References:


### Relevant MSSNY Policy:

#### 285.992 Specialty Society Committees to Eliminate Health Care Disparities

MSSNY strongly encourages all state specialty medical societies to form a Committee to Eliminate Health Care Disparities. These committees should share ideas and work together with MSSNY’s Committee to Eliminate Health Care Disparities as a coalition. MSSNY also strongly encourages all state specialty medical societies to incorporate within their CME courses, lectures and other academic activities, relevant information about access to care, health literacy, cultural competency, workforce diversity, management options, compliance, outcomes and other factors that relate to healthcare disparities in their respective specialties, including race, ethnicity, sexual orientation and gender identity. In addition, MSSNY should develop a scientific accuracy rating system and report for all proposed New York State legislation impacting clinical services to include whether or not the legislation adheres to specialty practice guidelines and appropriateness criteria. (HOD 2013-163)

#### 85.961 AMA Encouragement of State Medical Societies to Form Committees to Eliminate Health Care Disparities:

MSSNY’s Delegation to the American Medical Association will introduce a resolution at its next meeting requesting that the AMA (1) urge that the state medical societies that are not yet members of the AMA Commission to Eliminate Health Care Disparities join and participate in this important public health initiative and (2) strongly encourage all state medical societies to form a Standing Committee to Eliminate Health Care Disparities and that those committees share ideas and work together as a coalition. (HOD 2011-163)

#### 285.998 Equality in the Provision of Quality Health Care:

The Medical Society of the State of New York (MSSNY) reaffirms its longstanding principle that it is unequivocally opposed to any form of discrimination in the provision of quality medical care to any individual because of race, color, religion, sex, sexual orientation, ethnic affiliation, national origin, or underlying disease process. The Society calls upon all component county medical societies as well as its entire membership to: a) be vigilant as to the existence of any such discrimination in the provision of health care in their respective areas; b) expend every effort towards eliminating such discriminatory practices wherever they may exist, regardless of the settings in which the health care is delivered.

It is the position of MSSNY that the withholding of the best available care to any individual on a discriminatory basis is abhorrent to the Society, its membership, and the medical profession at large. The Society, therefore, vigorously affirms that equality of medical care should be scrupulously and compassionately afforded across the entire patient community, without exception.

MSSNY’s Committee to Eliminate Health Care Disparities will continue to work with the AMA Commission to End Health Care Disparities to encourage other State Medical Societies and Specialty Societies to establish standing committees to help eliminate health care disparities wherever they exist. (Council 1/20/00; Reaffirmed HOD 2004-174; Reaffirmed Council 9/9/04; Revised and reaffirmed HOD 2014)

### 117.975 Recommendations of White Paper: Improve EHR Satisfaction

MSSNY adopts the following recommendations to improve implementation and satisfaction among users of Electronic Health Records (EHR):

1. Improve design and workflow so that EHR:
   1. Doesn’t take away time spent with patients
   2. Does not interfere with doctor-patient relationship and
   3. Reduces total time spent on EHR per patient
   4. Workflow should be customizable not only to fulfill various needs of different specialties, but to accommodate needs of every individual physician as well.
   5. [sic] Reduce documentation that serves functions other than care of patients, and reconsider incentives and penalties.
   6. Reduce cost of EHR
   7. EHR should help generate necessary billing reports and allow e-prescription of medications
   8. EHR should prompt physicians about gaps in care of their patients and also help with clinical decision support.
   9. Improve interoperability between physicians and all healthcare providers. Peer to peer exchange should be the goal whether it is direct or through an exchange.
8. Improve value of notes in telling the patient’s story and the thought process of the physician rather than the volume of data.
9. EHR should capture episodes of care rather than encounters.

**Relevant AMA and MSS Policy:**

**D-478.995 National Health Information Technology**

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare and Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians’ practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology’s (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

**H-350.971 AMA Initiatives Regarding Minorities** The House of Delegates commends the leaders of our AMA and the National Medical Association for having established a successful, mutually rewarding liaison and urges that this relationship be expanded in all areas of mutual interest and concern. Our AMA will develop publications, assessment tools, and a survey instrument to assist physicians and the federation with minority issues. The AMA will continue to strengthen relationships with minority physician organizations, will communicate its policies on the health care needs of minorities, and will monitor and report on progress being made to address racial and ethnic disparities in care. It is the policy of our AMA to establish a mechanism to facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health, minority medical education, and minority membership in the AMA. Such an effort should include the following components: (1) Development, coordination, and strengthening of AMA resources devoted to minority health issues and recruitment of minorities into medicine; (2) Increased awareness and representation of minority physician perspectives in the Association’s policy development, advocacy, and scientific activities; (3) Collection, dissemination, and analysis of data on minority physicians and medical students, including AMA membership status, and on the health status of minorities; (4) Response to inquiries and concerns of minority physicians and medical students; and (5) Outreach to minority physicians and minority medical students on issues involving minority health status, medical education, and participation in organized medicine.

**D-350.995 Reducing Racial and Ethnic Disparities in Health Care**
Our AMA’s initiative on reducing racial and ethnic disparities in health care will include the following recommendations: (1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care. (2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities. (3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the “Doctors Back to School” program into secondary schools in minority communities.