ASSOCIATION MÉDICALE CANADIENNE CANADIAN MEDICAL ASSOCIATION

BACKGROUND TO CMA POLICY

EQUITY AND DIVERSITY IN MEDICINE

See also CMA Policy on Equity and Diversity in Medicine

RATIONALE

DEFINING EQUITY AND DIVERSITY

Equity means the treatment of people that recognizes and accommodates their differences by ensuring that every individual is provided with what they need to thrive, which may differ from the needs of others. It is a state in which all members of society have similar chances to become socially active, politically influential, and economically productive through the absence of avoidable or remediable differences among groups of people (defined socially, economically, demographically, or geographically). Equity in medicine is achieved when every person has the opportunity, with their own identity, culture, and characteristics, to create and sustain a career as, or receive care from, a medical professional without discrimination or any other cultural or characteristic-related negative bias or barrier.

Diversity describes those differences between people as manifested in their interactions with others in practice, learning, and societal contexts. Diversity includes those (observable and non-observable) characteristics which are constructed—and sometimes chosen—by individuals, groups, and societies to identify themselves (e.g., age, culture, religion, language, gender, sexuality, health, socio-economic and family status, geography) in different contexts. These characteristics may describe individuals in relation to others in those contexts. While identity informs perspectives and approaches, it does not mean that these will be the same for all people who share specific characteristics.

As part of equity and diversity frameworks, inclusion is often articulated to refer to strategies used to increase an individual's ability to contribute fully and effectively to organisational structures and processes. Inclusion strategies are specific organisational practices or programs focused on encouraging the involvement and participation of individuals from diverse backgrounds to integrate and value their perspectives in decision-making processes. Robust processes for inclusion are a vehicle to achieving equity and diversity. Thus, the process of inclusion can be understood to be positioned at the nexus of the overarching principles of equity and diversity.

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CONTEXT

Equity and diversity in medicine is an important, ongoing discussion for medical professionals and patients. The medical profession represents both opportunities and challenges for anyone seeking to become part of it. However, the opportunities available do not currently depend solely on individual merit but on many elements of identity and other personal characteristics, culture, and previous circumstance, sometimes through generations. The primary role of the medical professional, caring for patients and society, is also impacted by these complex, intersecting aspects. As the Canadian population becomes more diverse[1], the medical profession should accommodate this diversity. It can do so by becoming more diverse itself through increasing opportunities for all groups to enter the profession and realize their full potential within it. Benefits to direct patient care, physician health and wellness, and to the functioning fabric of the profession can flow from achieving diversity and equity.[2,3,4]

Equity is achieved when any given person has the resources and acceptance they need to have a similar chance as others to be a medical professional. This is the distinction between treating people equally and treating them as equals.[5] There are currently many areas of inequity to address, both in society and within the medical profession.

The available data indicate that the steps needed to address these challenges should be focused in both training and practice environments. This background document will explore key areas of training and practice that hinder equity and diversity in medicine and some of the progress being made to bolster it.

ACHIEVING EQUITY AND DIVERSITY WITHIN THE PROFESSION

Education (recruitment, retention, and training)

The many aspects of physician education, through the trajectory of initial recruitment, training, specialty selection, placement, and retention, are all areas where inequitable treatment has been identified for individuals and communities. Individuals who identify with more than one determinant of diversity or inequity often face compounded challenges.[6,7]

Several programs outside of Canada have attempted to address the problem of broader recruitment into the profession by strengthening the pipeline that leads to medical school applications—a strategy that shows promise but with some mixed results. A retrospective study of a long-standing Medical Education Development (MED) program at the University of North Carolina indicated that the intensive program resulted in high rates of medical school acceptance and eventual completion of a medical degree.[8] Another study following minority students within the Undergraduate Science Students Together Reaching Instructional Diversity and Excellence (USSTRIDE) program found that despite similar grade-point averages and lower MCAT scores to non-USSTRIDE students, their acceptance rate into medical school was far greater.[9] Limited evidence also suggests that an admissions framework that promotes holistic review of applicants using processes and standards that take into account medical school candidates' experience and attributes in a more comprehensive way alongside more

traditional metrics results in a more diverse pool with greater inclusiveness of underrepresented groups.[10]
A challenge identified in the pipeline approach is the need for an appropriate level of flexibility so that promising students are not restricted access or caused to leave prematurely.[11] This flexibility may extend to the kind of program being offered. For example, a study of medical school applications of underrepresented minority students and students from disadvantaged backgrounds found that these applicants were more likely to choose an MD-master's program in health equity, rather than the stand-alone MD program. This indicates that this type of offering may increase both the number of diverse applicants and, eventually, lead to greater numbers of physicians working with currently underserved communities.[12] In fact, studies of geographical disparities in health have made clear that the background and life experience of a medical graduate is very pertinent in predicting whether they will pursue their career in underserved areas.[13]

For those who make it into residency, attrition in some speciality areas is higher than in others. In the US emergency medical field for example, attrition was found to be statistically higher for both women and Hispanic/Latino residents than for other trainee groups.[14] A study based on related data found that the rate of Black persons entering plastic surgery decreased despite an increase in both Black medical school graduates and applicants to plastic surgery residency.[15] The authors of both studies raise the question of whether these groups face barriers to their inclusion beyond the reach of their studies. Few studies are informative of the situation in Canada. However, the trends in comparator countries indicate that there is a need to collect this data in order to determine where and how our system is failing in this area.

Despite the increasing representation of women in medicine—nearly half of all physicians in Canada are women, currently[16]—evidence shows that women face particular culture-based barriers to pursuing certain specialties in medicine. This is indicated most plainly where their numbers are not keeping pace with the overall trends. For example, this may be most clear in surgical specialties where surgical training can be seen as incompatible with pregnancy and childrearing.[17] Across the profession, women are often encouraged to follow career paths that allow for what is viewed as 'better' work-life integration for women, a situation that exemplifies gender inequity. As a woman medical student reflected: "I can't even tell you the number of times I've heard the phrase 'It's a good career choice for women.'"[18]

Finally, with respect to training, one study of medical students revealed the majority did not believe that an understanding of a patient's culture and related issues was needed to provide effective care; nor was an awareness of one's own cultural biases.[19] This blind spot about one's own biases and the role of cultural awareness in care provision was highlighted in another important study that revealed that while health care professionals believed they had the practical ability and applicable cultural knowledge to treat minority patients, many in fact lacked specific training and failed to identify larger systemic issues such as a recognition of racism, power imbalances, entrenched majority culture biases, and the need for awareness of one's own prejudices.[20] This finding is echoed by Indigenous peoples in Canada when seeking care,[21] making clear the need for cultural safety and competency training to address

these barriers.[22,23] There is also an ongoing effort to better understand the barriers people with physical or mental disabilities face in participating in health care research.[24] That study, and others, have shown that experiential programs may be much more effective than knowledge-based courses in equipping physicians for cultural awareness and safety.[25,26] Further, a study of nurses' use of race and genomic information found that those with higher educational degrees performed more similarly to those with minority backgrounds, suggesting that the training received during this additional education may be responsible for both the increase in use of information related to race, including genetic ancestry, in the clinical care they provided.[27]

Civility

The experience of peer-to-peer communication by physicians who self-identify as having a determinant of diversity has too often been shown to be poor. One study of internationally educated physicians practicing in Canada revealed that they most often reported discrimination as being attributed to colleague physicians.[28] Further, an analysis of the literature on bullying, undermining behaviour, and harassment in the surgical specialties, found that these behaviours were prevalent.[29] The experience of discrimination, harassment, and demonstrations of disrespect by peers and senior physicians has also been found to be prevalent for women.[30,31] This manifestation of professional culture is found to be frequently still tolerated in training or practice.[32,33,34] A 10-year interventionist study of a university-based health science faculty in California reveals how durable many of these behaviours are within the professional culture. Despite the success of measures introduced to increase the representation of marginalized groups within that faculty, there was no change, ten years later, in the reported rates of bullying, unwelcome sexually-oriented behaviours, or behaviours that could negatively impact patient care.[35]

ACHIEVING EQUITY AND DIVERSITY WITHIN HEALTH SYSTEMS

Work Environment (bias, discrimination, harassment, and pay inequity)

While there are ongoing efforts to increase representation of marginalized groups within the medical profession, bias and discrimination at the individual and systemic levels continue to create barriers to the advancement, health, and livelihood of many individuals. A recent NHS study of health care organizations in the UK showed rising levels of discrimination against minorities and a failure to advance them into managerial positions.[36] Women physicians also face particular behaviours in response to their gender, including sexual assault and harassment, which 30% of women physicians and learners report experiencing in their workplace or learning environment; nearly half of this group reported that these incidents negatively affected their career advancement.[34,37,38,39] One study found that 51% of women and 31% of men reported experiencing discrimination in the workplace – as such, discrimination in the workplace, in general, cannot be considered uncommon for physicians.

Pay inequity is another manifestation of cultural bias. Data from the UK National Health Service for 2017 indicated that while most differences were small, especially for younger groups of physicians,[40] the pay gap for under-represented minority physician consultants was approximately 5%.[41] For other allied health professions the data is much more

straightforward, with ethnic/racial minority professionals consistently earning less than their Caucasian counterparts.[40] This is a complex issue which will require ongoing study. However, evidence of gender-based inequity acts as a more demonstrable example of this phenomenon. Women physicians, on average, earn less annually in primary care (16% gap) and specialties (37% gap) than their male colleagues.[42,43] Multiple studies have found that remuneration disparities remain even after controlling for factors such as region, years of practice, participation in clinical trials, number of publications, specialty, age, hours worked, and practice characteristics.[44,45,46,47] As noted in the 2019 CMA-FMWC Discussion Paper on gender inequity and diversity in the medical profession, Canada's system for remunerating physicians may disadvantage women physicians who are not financially rewarded under the current schedule of benefits for spending more time with patients than on procedural tasks typical of male-dominated specialties.[4849,50,51]

Physician leadership (retention, advancement, and leadership opportunities)

As seen in the literature, the term physician leadership encompasses specific roles in clinical, administrative, or academic settings, as well as referring to informal demonstrations of role modelling, mentoring, and allyship. While context will determine the way in which the term is being used, the goal of physician leadership is always to improve the performance of individuals and organizations and ultimately, the quality and delivery of patient care.[52] Organizations with high levels of physician engagement in leadership roles were identified in one study as resulting from existing leaders fostering and promoting relationships with colleagues, then setting and role modelling expectations.[53] However, stereotypes and role expectations about both men and women physicians continue to negatively impact hiring, retention, advancement,[48,54,55] and career trajectories.[18,56] Evidence strongly indicates that the lack of growth in one's career and negative perceptions of collegiality in the workplace contribute to career dissatisfaction[57] and poor physician health and wellness.[55,58]

While it was previously noted that increasing the diversity of students in medical school is a critical first step in reducing stereotypes and changing hiring practices, creating the conditions for retention and advancement of physicians is more complex. A recent set of keys for success for under-represented minorities from the Research in Academic Pediatrics Initiative on Diversity (RAPID) U.S. National Advisory Committee illustrates some of the issues surrounding securing equity in medicine. RAPID keys to success, which can only be achieved with institutional support, include "having multiple mentors, writing prolifically, being tenaciously persistent, having mentors who are invested in you, dealing with families who do not want you to care for their child because of your race/ethnicity by seeking to understand the reasons and debriefing with colleagues, seeking non-traditional funding streams, balancing committee work with having enough time to advance one's research and career by using these opportunities to generate scholarly products, and asking for all needed resources when negotiating for new jobs."[59] For women physicians who are also mothers, their domestic responsibilities, which are often significant,[43,60,61,62,63,64] are often unrecognized and makes them vulnerable to exclusion from administrative decision-making (termed the *maternal wall*).[65] Having effective senior mentors has also been identified as part of a multipronged solution to increasing the number of women in medical leadership positions.[66,67] In the Canadian medical education system in 2018, women held 46%, 37%, and 22% of assistant,

associate, and full professorships, respectively.[68] Across these positions this represents an increase of approximately 3% in representation since 2010, the first year wherein this gendered data was collected. As indicated earlier, the impact of culturally-embedded bias and overt instances of harassment should also not be underestimated in discerning why there is less representation in these influential areas of women and other marginalized groups.

The development and implementation of programs and resources to support the skills and opportunities of marginalized and/or under-represented groups once they have entered the profession requires great commitment on the part of organizations and institutions wishing to improve the diversity of their physician cohort and equity of their recruitment and retention strategies. Research indicates that those facing the largest inequities are the least likely to be able to take advantage of these new opportunities.

For those physicians who wish to teach and practice in university health centres, one retrospective study looking at the association of research activities of medical trainees (in undergraduate, medical school, and residency) with eventual faculty appointment found that said research activities, along with authorship, academic achievement, and career intentions, were significant variables explaining the effect of race or ethnicity on faculty appointment.[69] Following on those findings, a longitudinal study out of the University of California San Diego Health Sciences Faculty between 2005 and 2015 provides some insight into effective methods for increasing faculty representation of marginalized groups.[35] Interventions included: changes in policy, such as family-oriented accommodations; new faculty development programs, including mandatory bias training; and the measurement of demographics and faculty-perceived climate. Using these methods, the percentage of women in faculty increased, the percentage of visible minority faculty increased, and some modest improvements in professional culture were noted including fewer derogatory comments, inappropriate jokes, and angry outbursts.

ACHIEVING EQUITY AND DIVERSITY WITHIN OUR COMMUNITIES OF SERVICE

Workforce diversity

Available data suggests that the Canadian medical workforce does not reflect the diversity of the patients it serves.[16,39] This is relevant because it has been argued, with evidentiary support, that physician's social and cultural competency is best developed by increasing the diversity of the physician workforce itself.[4,39] Those physicians who are members of under-represented communities are more likely to believe the profession is responsive to their needs when they are proportionally represented in it.[70]Increasing diversity in the medical profession appears to play a role in increasing access and positive experience for diverse patients, with important socioeconomic and cultural safety ramifications. A U.S.–centred study found, for example, that family physicians from a minority ethnic/racial background care for a disproportionately higher number of minority ethnic/racial patients (54%) as well as non-English patients (70%).[4] Another U.S. study investigating nurses' self-reported use of racial factors in clinical evaluation found that nurses from minority backgrounds were significantly more likely to use these factors than their Caucasian counterparts to provide insight into patient needs.[27]

Patient care

The NHS Institute for Innovation and Improvement in its 2013 publication, the Patient Experience Book, defined that patient experience as "what the process of receiving care feels like for the patient, their family and carers" noting that "it is a key element of quality, alongside providing clinical excellence and safer care." Don Berwick, in alignment with others in the US[71,72,73,74] and in Canada[75] identifies the elements that create the desired patient experience as "transparency, individualization, recognition, respect, dignity and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care."

User surveys exploring the patient experience and its correlative, person-centered care, report that the coordination and continuity of care, and ease of access to needed health resources is high on patients' wish list in these areas.[76]Marginalized ethnic groups' feedback that navigating health care systems requires hyper-vigilance to receive high quality care[77] helps illustrate the current perception and experience of these groups when interacting with health care providers and institutions. In one study, two-thirds of physicians and medical students acknowledged that experiencing bias affects the care decisions of minority-identifying patients.[78] This is relevant because individuals who experience bias and discrimination have worse health outcomes than those who do not.[79] In a health care context, what may lead to negative interactions with physicians may not primarily be the visible manifestations of ethnicity and culture, but as a recent large-scale study demonstrated, the education level and language proficiencies of patients.[80] Supporting the role of language as an important element of diversity in the context of medical care, another large U.S. study found that non-English preferring patients almost always had lower scores for their in-patient experiences. This study also found that these patients often accessed hospitals with lower experience scores overall, which may be the result of access barriers or patient choice based on linguistic or cultural reasons.[81] One study identified providers' lack of awareness of resources and (where they exist) suboptimal resources, constrained cultural competency training, limited workplace diversity, lack of community outreach programs, and mismanagement of the unvoiced patient as barriers that health care providers face in providing quality care to diverse patient populations.[82]

As indicated in the section on Education, the preponderance of evidence reveals that greater understanding of cultural factors and other personal determinants, together with a self-awareness of prejudice and bias, help physicians and institutions create a professional culture that is welcoming to all participants and responsive to the communities they serve.[83,84] This is supported by developing research that has shown that racial concordance in the patient-health practitioner relationship is often found to be beneficial, although its relationship to greater satisfaction with the care provided is variable among ethnic groups.[85] This effect may be in part a reflection of a naturally empathic communication style employed by individuals who share the same cultural characteristics. As a growing body of evidence shows, this style can be employed by any physician with positive results for patients. For example, two studies have shown that when this approach was employed by women physicians to patients across a diversity of backgrounds, it led to greater patient satisfaction and adherence to preventative and curative interventions—effectively illustrating that a trusting relationship established

through empathetic communication has positive benefits for patient care.[86,87] Because this field of study is still emerging there is a need to foster and sponsor research of this type, along with other diversity-related healthcare research. This would provide insight into best practices and training options for both new and existing physicians to reduce disparities and promote the best patient care possible.

BUILDING MOMENTUM IN ATTAINING EQUITY AND DIVERSITY

Greater equity and diversity in the medical workforce has positive implications for system adaptation and patient care, but there are many barriers that need to be addressed for the profession to move forward. Momentum in addressing equity and diversity in medicine appears, so far, to have been largely academic and research-oriented, though the landscape is changing quickly. For example, within the gender equity movement there is a growing number of initiatives, leadership courses, and outreach opportunities, especially in the past few years. These efforts are often aimed at creating discourse and support, though some are attempting to address specific ongoing disparities such as those found in funding or representation within academic leadership.[88,89] Institutional level policy changes addressing aspects of gender equity are also forthcoming, such as the implementation of interventions which provide resources for trainees and clearly advance expectations for faculty.[90]

A growing number of guidelines, policies, and programs are aimed at addressing some of the disparities in overall diversity.[3,88,89,91] Further, movements to better establish equity and diversity within medical education and professionalism are accelerating.[91,92,93] These changes, impacting policy, organizational structure, and curriculum, provide for a foundation of support for equity. However, to effect meaningful change, system-wide changes are needed.[3,94] There are now calls for formal legislation or regulation to address systemic inequities and facilitation of organizational culture change at the institutional level, alongside professional development at the individual level.[95] Frameworks, legal or otherwise, to address inequity should not solely focus on assessing external outcomes, such as population served and associated outcomes. They should also look inward towards assessing existing organizational culture and providing the capability to translate such frameworks into the many contexts present in larger institutions and systems.[96]

There are also calls for advancing curriculum development to teach proficiencies such as cultural competence and knowledge of specific inequity areas.[83,97,98,99] There is impetus to provide exposure and longitudinal learning in these areas to reduce barriers for patients and sustain momentum.[99] A key emerging theme is that experiential programs create a better understanding for those requiring educational or professional development experience in cultural competence, while individuals from marginalized groups can be better included through long-term engagement efforts and individualized access to mentors and resources.[100,101]

With this in mind, a definitive shift in both medical degree programs and residency programs is needed to move towards a more inclusive culture. The cultural competence needed by medical instructors in order to foster equity and diversity have been summarized as including aspects such as critical self-reflection of individual and cultural biases, communication in non-discriminatory ways, empathy for people from diverse backgrounds, awareness of intersectionality, knowledge of ethnic and social determinants of health, awareness to understand and communicate social or cultural contexts to students, and the ability to engage, motivate, and encourage participation by all students.[83]

The literature sets out a number of additional recommendations and paths forward. First and foremost among these recommendations, the need for high quality data is a necessity in gauging the baseline of any environment and the effectiveness of any intervention. This includes organizational and institutional equity-related data but also speaks to the need for further work creating and standardizing assessment tools.[102,103,104] Administrative emphasis, process evaluation, and education are further areas to stress in the delivery of equity-related programs, frameworks, and policies.[105] Committed, strategic leadership is likely key to sustain this action in order to find and mitigate inequities and barriers within institutions.[106] It should be noted that assessing the impact of programs in this field is difficult due to the complex and multifaceted nature of equity within the culture of medicine; as such, it is important to acknowledge calls to adopt an integrated perspective on these many facets and to act on multiple system levels in a concerted fashion[94] so as to transform momentum into tangible results.

GLOSSARY

Allyship

Allyship recognizes that there is a role for those who are not members of disadvantaged groups to address the bias and discrimination those groups face. It involves recognizing that the benefits a person has derived from their own privilege can be unearned, and taking an active role in addressing imbalances that arise out of that privilege, including changing patterns of behaviour.[107] Behaviours related to allyship include being aware of one's own prejudice; adopting a listening posture that leaves space for others to speak and act; challenging discriminatory or biased behaviour and policies, practices and procedures; and supporting and empowering others and advocating for change.[108]

Cultural Awareness

Cultural awareness, from the standpoint of a health care provider, can be viewed as being sensitive to the ways in which community members' values and perceptions about health care differ from their own.[109] Implicit bias is a related concept, wherein people act on the basis of internalised schemas of which they are unaware and thus can, and often do, engage in discriminatory behaviours without conscious intent[2] This tendency is often linked to cultural differences.

Cultural Competence

As put forward by the Association of American Medical Colleges, "cultural and linguistic competence is a set of congruent behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross-cultural situations." 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups. 'Competence' implies having the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices, and needs presented by patients and communities.[110] Cultural competence and cultural humility are overlapping concepts. When cultural competency is understood to include not only understanding of cultural differences, but a commitment to behaviour, cultural competence expresses the same values as cultural humility.[111] Committing to cultural competence allows individuals and institutions to foster cultural safety.

Cultural Humility

Cultural humility involves a commitment to a continuous process of recognizing and understanding cultural differences in interactions with others (such as patients and colleagues), recognizing intentional or unintentional biases they may have, and correcting them. Exercising cultural humility involves an attitude of lifelong learning about cultural differences and related power imbalances. It involves a physician's commitment to self-reflection and self-critique about cultural perceptions, including the biases they bring to

interactions with others. Exercising cultural humility allows practitioners to develop partnerships with others that are free from discrimination and bias. As described above, cultural competency and cultural humility are overlapping concepts. However, some argue that cultural humility is a more precise term than cultural competence for this concept because it expresses the need not only for cultural knowledge, but for a commitment to a certain set of behaviours.[111,112] In committing to cultural humility, individuals and institutions foster cultural safety.

Cultural Safety

Williams defines cultural safety as "the availability of an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together."[113] In the health care setting, incorporation of cultural safety requires the adoption of cultural humility or cultural competence to understand and address the limitations of the skills, knowledge, and attitudes of health providers in regard to their patients. In Canada, this includes a postcolonial understanding of the health disparities and inequities among First Nations, Inuit, and Métis through the examination of the effects of colonialism on the lives of Aboriginal peoples.[114]

Disability

According to the World Health Organization, disability is "an umbrella term for impairments, activity limitations, and participation restrictions. Disability refers to the negative aspects of the interaction between individuals with a health condition (such as cerebral palsy, Down syndrome, depression) and personal and environmental factors (such as negative attitudes, inaccessible transportation and public buildings, and limited social supports)."[115] Effectively, disability is a complex phenomenon that is individually-defined and involves an interaction between a person's body or mind and features of the society in which they live.[116]

Diversity

Diversity refers to differences between people, especially in the larger societal and cultural context. As a simple definition, Section 15 of the Canadian Charter of Rights and Freedoms describes these differences as pertaining to race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability.[117] However, diversity can be expanded to include other related aspects such as gender, sexuality (LGBTQ2+), socioeconomic status, urban or rural location or upbringing, and neurological differences not always included as disabilities (neurodiversity).

Equity

Equity refers to the treatment of people in a way that recognizes and accommodates their differences and to the situation in which all members of society have similar chances to become socially active, politically influential, and economically productive. Equity is therefore the absence of avoidable or remediable differences among groups of people – whether those groups are defined socially, economically, demographically, or geographically – with respect to accessing those opportunities.[118]

Intersectionality

Intersectionality describes the way in which the layering of discrimination based on multiple characteristics (such as culture, gender, sexuality, indigeneity, ability, socioeconomic status) has a compounding effect on the level of privilege individuals have and the discrimination and bias individuals can face. Recognizing intersectionalities allows individuals and institutions to account more precisely for the way in which individuals and groups are treated (both positively and negatively) by the overlapping elements of their identities and how that differential treatment can be addressed.

Marginalization

In brief, "marginalization is both a condition and a process that prevents individuals and groups from full participation in social, economic, and political life enjoyed by the wider society."[119] Therefore, marginalized persons or groups are those experiencing inequity.

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