

COMMENTARY

Intentionality Required to Equip a Diverse Physician Workforce with Tools and Infrastructure to Deliver Comprehensive Care

Octavia Amaechi, MD

Family physicians who self-identify as Black, Hispanic, and American Indian/Alaska Native (AIAN) are more likely to provide care to historically marginalized patients and provide care in disadvantaged areas compared with their White counterparts. However, these physicians also tend to have a narrower scope of practice. Broader scope of practice, determined by the Scope of Practice for Primary Care score, is associated with higher quality of care. Therefore, historically marginalized patients and those in disadvantaged areas would greatly benefit from a physician workforce with a broad scope of practice to help combat long standing and pervasive health inequities. This commentary will visit the context of this issue and provide suggestions to equip and support a diverse physician workforce to deliver trusted and comprehensive health care. (J Am Board Fam Med 2022;35:597–600.)

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A public health crisis continually looms before us: that of systemic racism and bias and the resulting effects of disparate care and health inequity for communities, families and individuals who are historically marginalized. Systemic racism and bias lead to the disproportionate burden of negative outcomes for patients marginalized and made vulnerable across geographic settings and across health conditions.^{1–2} This is heightened in areas where access to health care is already limited.³ Racism and bias are embedded in policies and practices of our governing bodies, health care delivery systems, and institutions of medical education and training. It dampens the health care delivery experience for individual clinicians, and importantly dampens the experience for patients as well.⁴ Health

inequity resulting from unaddressed racism and bias increases the cost of health care, is associated with higher incidence of hospitalization, leads to faster progression and complication of chronic diseases, and inflates morbidity and mortality.⁵

Racism and bias contribute to disparate care and health inequity in a myriad of ways. For example, poor inclusion of diverse groups in research studies and use of flawed race-based algorithms lead to both a delay in diagnosis and poor access to medical services and resources.⁶ Clinicians' implicit bias can be passed along in medical record documentation, such as the disproportionate incidence of negative descriptors assigned to Black patients.⁷ These practices can skew future decision-making processes from other clinicians, lead to substandard care and perpetuate health inequity. Many minority and disadvantaged patients with or at high risk for chronic disease do not have a medical home and lack a primary care physician altogether.³ This eliminates the opportunity for health concerns and questions to be addressed. It removes the potential for early screening, counseling on disease prevention and removes the opportunity to mitigate chronic illness progression. The task of addressing racism as a public health crisis is complex as it requires a uniform commitment to continually identify, evaluate, and critique drivers

From Spartanburg Regional Family Medicine Residency Program, AHEC Assistant Professor, Medical University of South Carolina.

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Corresponding author: Octavia Amaechi, MD, Spartanburg Regional Family Medicine Residency Program, Medical University of South Carolina, 853 N Church Street Suite 510, Spartanburg, SC 29303 (E-mail: OAmaechi@srhs.com).

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of health inequity and also requires layers of support for interventions targeting harmful policies and practices on many levels and in different sectors.

What is known, however, is the positive impact in health care outcomes when there is physician - patient concordance by race, ethnicity, and language for historically marginalized groups.⁸⁻¹⁰ Shared cultural experiences likely strengthen the therapeutic alliance and diminish implicit biases when such physician - patient relationships are established. Specifically, there is improvement in communication, allotted time spent together, longer and more detailed clinician documentation, improved rates of screening modalities and immunizations, and improvement in patient perception of treatment with demographic and linguistically concordant care.^{9,10}

In addition, comprehensive primary care services are especially needed in disadvantaged areas where access to subspecialty care is limited. Family physicians providing broader scope of care is associated with lower health care costs and reduced rates of hospitalization.¹¹ Physicians who provide a broader scope of care also tend to have less feelings of fatigue and burnout which can improve career retention and longevity.¹²

I read with great interest Wang, T et al's policy brief, "Variation in Scope and Area of Practice by Family Physician Race and Ethnicity." It reports that although Black, Hispanic, and AIAN family physicians are more likely to provide care to historically marginalized patients and serve in more disadvantaged areas, their scope of practice is narrower compared with their White counterparts.¹³

A broad scope of practice was determined by the Scope of Practice for Primary Care (SP4PC) score, intended to measure the breadth of practice by family physicians' self-report of performing 22 separate clinical activities representing usual aspects of family medicine training and scope of practice. A higher SP4PC score is associated with higher quality of care. Therefore, a narrow scope of practice is a potential barrier to the delivery of quality comprehensive primary care to patients and communities who need such services the most to help combat long standing and pervasive health inequities. Although work to address and remove the drivers of health inequity is imperative, so is providing the current and budding diverse physician workforce the tools and supportive infrastructure necessary to deliver quality comprehensive care wherever needed.

Equip a Diverse Workforce

What tools are needed to prepare diverse physicians to meet the complex needs of the communities they often desire to serve? One answer lies in creating tailored educational plans for resident physicians. Proposed updates to the structure of Accreditation Council for Graduate Medical Education (ACGME) accredited Family Medicine residency programs include the creation of individualized learning plans. Individualized learning plans would provide dedicated, supported space and time for residents to consider their intended area of practice, perform a needs assessment of the prevailing health care inequities of that community, perform a similar assessment of their training and career goals and choose electives accordingly. With ACGME proposing at least 4 months of residency training to be tailored to future career needs, this would allow physicians in training to garner meaningful, practical skills and experiences before entering independent practice.

Program directors and residency faculty tasked with creating individualized learning plans should include consider recommendations from community preceptors and collaborate with local resource partners to allow residents to learn from those with knowledge, experience, and dedication to the community where the trainees' future practice is planned. Moreover, as we do not have enough diverse physicians to provide concordant care for historically marginalized patients across all settings, family medicine residency programs should continue to explore and adopt meaningful training practices to offset health inequities and provide comprehensive quality care for these populations.

Support a Diverse Workforce

An equipped and prepared diverse family physician workforce requires a supportive infrastructure to facilitate comprehensive primary care. Often family physicians have intentions of providing broad scope care on completion of residency training.¹⁴ However, barriers may prevent physicians with valuable skills to practice within their full scope. Barriers may include policies that limit credentialing, especially in more suburban and urban settings. Lower reimbursement to family physicians compared with subspecialists for procedural care and costs of malpractice insurance coverage may also deter family physicians from providing broader scope care. Costs associated with maintaining expertise and certification requirements

may not be reimbursed by employers, especially if broader scope of practice for family physicians is not a local operational priority. Flexibility in patient scheduling is also necessary to accommodate the varying office visit encounters or practice location variations where a family physician may provide care. Support for flexible physician scheduling is important as it would promote physician work life balance, wellness and possibly improve rates of URM physician retention as well.¹⁵ More robust policies are needed to focus on incentivizing and supporting physicians who provide high quality and comprehensive primary care to marginalized populations and in disadvantaged areas.

Build a Diverse Workforce

Whereas the focus of this commentary is to provide strategies to equip and support a diverse physician workforce to provide a broad scope of primary care services, 1 thing is essential: such a workforce must first be built. Although the call to diversify the physician workforce is ongoing and clear, tangible, and well-designed efforts to answer this call over preceding decades have not made a substantial impact. Overall, the ethnic and racial diversity of the physician workforce has remained stagnant and does not reflect the diversity of the general population.¹⁶ Endeavors such as pipeline programs, specific mentorship, and recruitment strategies have been successful in individual instances. However, these efforts are siloed; often dependent on limited funding, limited resources, and limited support from those in positions of power and end when funding sources and local priorities change. Institutional and broad scale health policy changes accompanied by requirements to address health inequities are necessary which include building and retaining a diverse physician workforce.

To build a diverse physician workforce, strategies are needed that start earlier in the educational path of students, to counter the effects of systemic racism and bias that exist in other sectors of society, such as the education system. Presenting medicine as a tangible career option to children from marginalized communities at every educational level, supporting diverse students' interests in medicine and offering multifaceted approaches to prepare them for the rigors of medical training, will improve efforts to build a physician workforce prepared to

meet the needs of the diverse patients' family physicians care for.

Intentionality is required at every level, and across sectors to build, equip and support a diverse family physician workforce. Delivery of broad-spectrum comprehensive care will not happen by chance. We must use the tools available now, while advocating for supportive infrastructure to ensure future access to high quality care and reduction of health inequities for historically marginalized communities.

To see this article online, please go to: <http://jabfm.org/content/35/3/597.full>.

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