POLICY BRIEF

Racial Inequities in Female Family Physicians Providing Women's Health Procedures

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Patient-physician race concordant dyads have been shown to improve patient outcomes; the race and ethnicity of family physicians providing women's health procedures has not been described. Using self-reported data, this analysis highlights the racial disparities in scope of practice; underrepresented in medicine (URiM) females are less likely to perform women's health procedures which may lead to disparities in care received by minority women. (J Am Board Fam Med 2023;00:000–000.)

Keywords: **Abortion, Contraceptives, Cultural Diversity, Healthcare Disparities, Patient Care, Patient Satisfaction, Physician-Patient Relations, Reproductive Health, Women Physicians, Women's Health Services**

Female family physicians (FPs) are valuable providers of women's health care in the United States. However, little is known about the demographics and number of FPs providing women's health procedures. Previous studies show that gender, ethnic, and racial concordance in physician-patient dyads result in lower costs, improved outcomes, and improved access, which may help to reduce disparities in minority women.[1,2] Females and non-White physicians are underrepresented in medicine (URiM) and lack of representation may exacerbate health care disparities. We sought to determine the race and ethnicity of female FPs providing women's health procedures in the United States.

We conducted a cross-sectional analysis from the American Board of Family Medicine's Family Medicine Certification Examination Registration Questionnaire from 2017 to 2021. The survey is administered to all ABFM diplomates seeking recertification, and has a 100% response rate. Demographic data are self-reported. Participants were asked which women's health procedures they currently provide. We categorized care based on 6 categories as follows: long-acting reversible contraception (intrauterine device and implantable contraception), diagnostic care (includes endometrial biopsy and colposcopy procedures), maternity care (includes prenatal care and deliveries), pregnancy termination, dilation and curettage, and uterine aspiration, and any women's health procedure. The data were stratified by race/ethnicity of the FPs and combined into 5 groups: non-Hispanic White, non-Hispanic Black, non-Hispanic Asian, Hispanic/Latinx, and non-Hispanic other (including non-Hispanic American Indian/Alaskan Native and non-Hispanic Native Hawaiian/Pacific Islander and non-Hispanic other).

Of the total 14,339 female FPs in the study sample, 60% were non-Hispanic White, 20% were non-Hispanic Asian, 8% were non-Hispanic Black, 7% were Hispanic/Latinx, and 6% were non-Hispanic other. Overall, we found that White FPs provided the greatest proportion women's health procedures, whereas non-Hispanic Asians provided the lowest proportion of women's health procedures across all categories (White = 21%, Asian = 11%, $P < .001$) (Figure 1). The provision of long-acting reversible contraceptives (LARC) was similar between White FPs = 36%, and Hispanic/Latinx FPs = 35%; there was a significant drop off for

This article was externally peer reviewed.
Submitted 28 February 2023; revised 13 June 2023; accepted 20 June 2023.
This is the Ahead of Print version of the article.
From the Robert Graham Center for Policy Studies in Family Medicine and Primary Care, Washington DC (GW, RL, AJ, YJ, AH); Virginia Commonwealth University, Department of Family Medicine and Population Health, Richmond, VA (AH).
Funding: None.
Conflict of interest: None.
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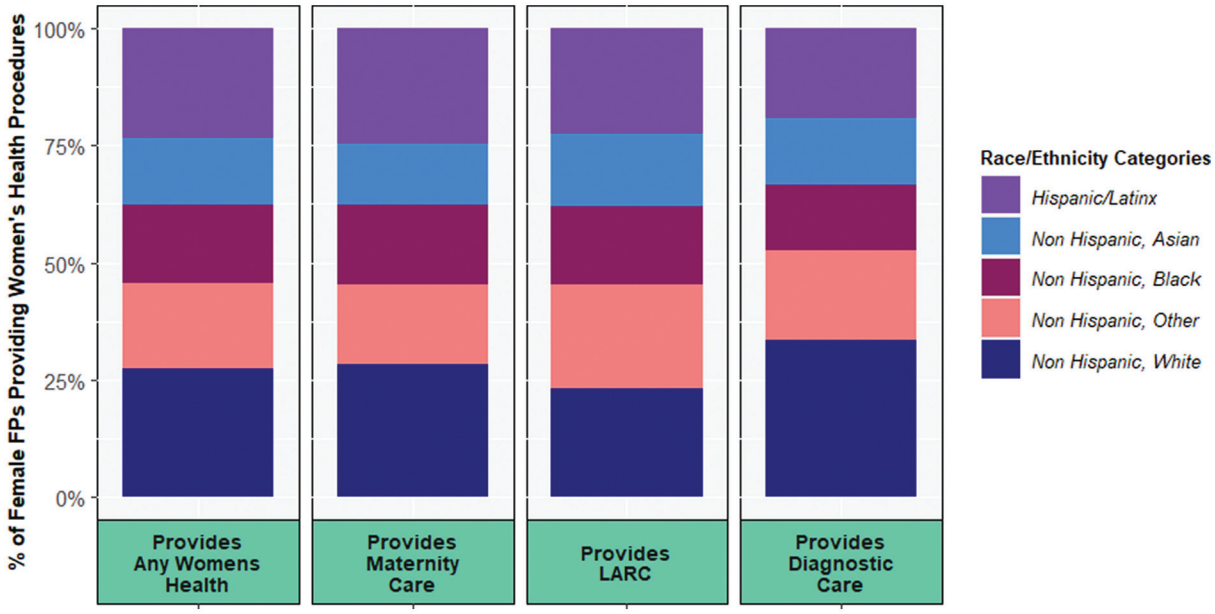
Figure 1. Proportion of female FPs providing women's health procedures by race and ethnicity. *Abbreviations*: FP, Family Physician. LARC, Long Acting Reversible Contraception.



Notes: Hispanic/Latinx (n = 996). Non Hispanic, Asian (n = 2,830). Non Hispanic, Black (n = 1,121). Non Hispanic, Other (n = 855). Non Hispanic, White (n = 8,537). Any Women's Health Services (n = 2,545 for "Yes"). Diagnostic Care (n = 719 for "Yes"). LARC (n = 917 for "Yes"). Maternity Care (n = 1,805 for "Yes").
Data Source: American Board of Family Medicine's Family Medicine Certification Examination Registration Questionnaire, 2017 to 2021 (n = 14,339)

both Black and Asian FPs ($P < .001$). A similar trend was noted for the provision of diagnostic care. For maternity care, 15% of White female FPs provided this care, whereas a much smaller proportion of Black, Asian, and Other race/ethnicity provided this care. Pregnancy termination, dilatation & curettage, and uterine aspiration were excluded, due to few FPs reporting these procedures. Across all race and ethnicity categories, the Native Hawaiian/Pacific Islander and American Indian/Alaskan Native accounted for the smallest representation of female FPs; these categories were combined with the non-Hispanic other category to ensure confidentiality.

The results show that female FPs do not provide procedures at consistent rates across races and ethnicities. This disparity is especially important given that FPs serve a diverse patient population,[3] therefore, making it difficult for patients to find a concordant physician. In addition, URIM and female FPs are more likely to work in diverse, underserved communities of high need,[3,4] where concordance may help to reduce disparities in women's health.

To combat disparities in the provision of women's health procedures, institutions should support URIM female FPs who wish to provide these procedures and work to dismantle barriers, such as credentialing challenges, inadequate training,[5,6] and poor reimbursement.[7] Training institutions should ensure that medical students and residents receive training in women's health procedures.[8] Most importantly, medical schools should actively recruit diverse trainees, to ensure diversity of the workforce in the future.[3] Further research should evaluate solutions to diversify the workforce providing women's health procedures.

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