EDITORS' NOTE

Health Care Equity for Family Medicine Patients and Family Physician Equity

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This is the first of two sequential equity and diversity-themed *JABFM* issues. Multiple articles address the social justice tenet of family medicine; ie, diversity and equity issues within the family medicine field and health care equity in the delivery of care to diverse patient populations. Within the field, we have a paper on how ABFM attempts to ensure equity in the board examination through differential item analyses review. Other articles report on the diversity of family physicians, the languages they use in their practices, family medicine department chairs, and deans of schools of medicine, as well as the diversity of the patients in family physician practices. Gender inequity is also important for family medicine. For care of diverse populations, there is a discussion of pseudofolliculitis barbae implications, race-specific blood pressure medications and control, location of family physicians and of social services by need, and a large study of laboratory testing by gender. Articles on various clinical topics are also included. (J Am Board Fam Med 2022;35:1–4.)

Equity in the Specialty of Family Medicine

Family physicians are more likely to self-identify as being a member of racial groups under-represented in medicine, compared with other specialties, and minority family physicians (from 6 potential response categories plus Hispanic ethnicity) are an increasing percentage of those taking the ABFM certification examination.[1] An increasing percentage of family physicians answer "yes" to the question: "Do you personally provide care in a language other than English?" and more report providing care in additional languages other than Spanish.[2] Similarly, diversity of department chairs in family medicine is greater than for many clinical departments, but no clinical department is fully representative of the racial/ethnic diversity of the US general population.[3] Medical school deans are also not representative of the US population for non-White race, female gender, or the specialty of family medicine.[4]

Gender equity is also a concern for the profession. It is well known that women physicians make less than men physicians. But is that true in family medicine, a specialty that prides itself on fairness and equity? Unfortunately, yes. At 3 years out of residency, women family physicians make one sixth less than men per hour.[5] This is clearly not equitable. One plausible explanation is that women physicians tend to spend more time with patients,[6] but much reimbursement is not strictly time-based.

Do you know what "Different Item Functioning (DIF)" is or how it functions with the ABFM Board Examinations? It is the unique (among US boards for physician certification) mechanism to ensure equity for test-takers by reviewing test items with differing percent correct answers by the self-identified gender and race/ethnicity of the examinee.[7] The good news behind what could be a complicated topic is that the reviewing committee found very few issues … an example of the specialty of family medicine striving for equity.

Our call to action comes from Sturges et al,[8] clearly best described by the challenge posed in the title: "Can Family Medicine's Counterculture History Help Shape an Anti-Racist Future?"

Clinical Health Equity Issues

Waivers from required shaving for men with pseudofolliculitis barbae (quite common in Black men) can be difficult to obtain and sometimes must be renewed as often as every 2 months.[9] The authors state the required waivers are a racial injustice. After all, other than during a pandemic, what type

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of work physically requires that men must be clean-shaven? Family physicians can both recognize the clinical issue and ADVOCATE for their patients.

Although Black patients were likely to receive the race-specific medications for hypertension recommended, their blood pressure is less likely to be controlled, suggesting therapy was not stepped up when needed.[10]

Life satisfaction is lower among some older American adults by ethnicity (defined with a high level of specificity); for many readers, the results will be surprising.[11]

Unfortunately, higher county-level economic inequality is associated with lower average health status, but less well known is that that same inequality is associated with fewer family physicians, as found in North Carolina.[12] How much of a county's poor health status can be explained by local family physician shortages?

Care coordination can make a difference in health care access. In this report by Saluja et al[13] in Los Angeles County, interaction with navigators was associated with more health care access. However, in Richmond, Virginia, most programs for social needs are not located near the patients who most need those specific services.[14]

For the same presenting bodily symptoms, women often receive less additional testing than men. Less additional testing does not necessarily mean less disease, or does it? Ballering et al[15] explore this phenomenon and resulting diagnoses for almost 20,000 patients presenting with common somatic symptoms in the Dutch Family Medicine Network.

Poleshuck et al[16] discuss the National Academies of Sciences, Engineering and Medicine's consensus report that identified 5 critical system-level activities to facilitate the integration of addressing social needs into health care and argue that these changes must begin with integrative primary care. Food security is one of the social determinants of health; food insecurity negatively impacts health. Nederveld et al[17] explore how clinicians, office staff, and community members understand and address food insecurity. Interviewees were generally positive about clinically screening for food insecurity, but many individuals were uncertain of the impact practices can have. One key sentence to remember: "Health care workers were unsure of how HIPAA regulations apply to sharing of social determinants of health-related information, an issue that is not entirely clear despite recent efforts to integrate screening and referral into practice."

Dr. Steven Lin[18] understands artificial intelligence (AI) and its potential uses in medicine. He does a great job explaining the concept to those of us who are confused or "scared" of what AI is and could be, while simultaneously discussing its potential—both positive and negative—related to health equity.

Additional Topics

A unique paper for JABFM is about COVID-19 testing for the National Basketball Association support personnel at Disney World, noting the advantage of "immediate" (results within 2 hours) over send-out testing.[19] Sensitivity and specificity were excellent.

Colorado was an early state to legalize recreational marijuana and to allow prescriptions for medical marijuana. Kondrad and Reed[20] explore Colorado family physician attitudes and practices related to medical marijuana and compare to a previous survey.[21] Striking differences in opinion emerged between family physicians who do and those who do not recommend marijuana about risks and physician association with marijuana dispensaries.

As a reminder of the importance of an ongoing physician–patient relationship, Mirer et al[22] find medication-assisted therapy for opioid addiction integrated into primary care doubles the retention rate in therapy compared to therapy provided outside of the patient's primary care practice.

Practice-based research networks have made important contributions to the literature base for family medicine. Nederveld et al[23] describe the development of a new network in Colorado. Of particular note is the strong interest of the community in the process and the use of photovoice and nominal group technique to develop network relationships and processes. In the EvidenceNOW trial (a large-scale facilitation-based quality improvement (QI) initiative in small and medium primary care practices),[24] the most common practice disruption was clinician departure, yet the investigators report that practices were able to continue to work on QI activities. Some of this continued work was contributed by practice facilitators.

Since hyperuricemia is associated with a higher risk of cardiac disease, the authors[25] analyzed clinical trials with a network meta-analysis to ascertain outcomes by specific treatment (allopurinol vs febuxostat) used to lower uric acid. In addition to the expected decreases in uric acid levels, there were no major safety events (and specifically, no increase in feared cardiac events), and allopurinol

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was found to lower uric acid more *and* be protective of kidney function.

In a large study with almost 17,000 women, those with diabetes were less likely to complete a mammogram after an order was written.[26] Black women were not less likely than others to get a mammogram but are known to die more frequently from breast cancer.

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