EDITORS' NOTE

This Issue's Emphasis: Inequity and COVID-19, Intertwined

Marjorie A. Bowman, MD, MPA, Dean A. Seehusen, MD, MPH, and Christy J. W. Ledford, PhD

This issue continues our tradition of advancing family medicine by publishing articles on issues that affect patients and the practice of family medicine, specifically with an emphasis on inequity and the COVID pandemic, which are often intertwined. We have articles on topical issues such as appropriate transgender care, newer diabetes medications, transportation as a social risk, and a thought-provoking commentary on ableism. A clinical review on olfactory loss takes on new meaning. Oregon Medicaid coverage policy supported family physicians assisting their patients by decreasing their opioid use, and a article suggests that buprenorphine should be decriminalized. Strengthening the desire to enter family medicine before starting medical school can help meet future patient needs. (J Am Board Fam Med 2022;35:215–218.)

JABFM endeavors to better people's and population health through publishing articles that inform clinicians, health care workers, policy makers and (sometimes directly) patients. Thankfully, the supporting organization for *JABFM* (ABFM Foundation) has agreed to increase the accessibility and timeliness of articles by publishing articles ahead-of-print, to begin later this year.

Equity and Inequity

Family medicine continues to work toward workforce equity and representation. Although family medicine attracts a higher proportion of underrepresented in medicine (URM) physicians than other primary care specialties, it is not sufficient to meet patient needs.[1] URM physicians care for more minority patients than non-URM physicians do. The interest of minorities and women in research participation generally and on specific research topics is explored by Shabu et al.[2] The need for specialized skills is highlighted by the (socio)linguist who has assisted the American Board of Family Medicine to ensure equity in the certification examination.[3]

In strides toward clinical equity, 1 large family medicine office [4] sought to improve care of transgender patients through staff training and chart reviews of appropriate patient identification and for unreceived, but needed, care. Findings highlight substantial needs for improvement. Research by Martinez et al[5] validate the Group-Based Medical Mistrust Scale (GBMMS) questionnaire for Spanish speakers. Clinician inertia and financial or other factors probably contribute to racial medical inequities. For example, based on increasing positive data, glucagon-like peptide-1 agonists (GLP-1a) and sodium-glucose cotransporter-2 3 inhibitors (SGLT-2i) are recommended in selected patients with type 2 diabetes, yet current prescriptions do not match needs for African-American patients, as seen in this report from a large health system.[6]

Transportation needs can also create inequity. Although a number of patient-facing tools include transportation, none adequately considered many relevant aspects of transportation difficulties patients face as found by Razon and Gottleib.[7]

A pointed and thought-provoking COVID commentary[8] notes that, "pervasive ableism among medical providers leads to a variation in the medical care options that are provided to people with intellectual disabilities and their families."

COVID-19

COVID-19 has brought new urgency to a common problem—olfactory (chemosensory) loss. Rowan et al provide a comprehensive clinical review for primary care clinicians.[9] On the opposite side of the pandemic—prevention—vaccine hesitancy is prolonging the COVID-19 pandemic. Boness et al[10] provide a practical strategy to enhance vaccine uptake with motivational interviewing. This is a takeaway clinicians can start immediately.

Conflict of interest: The authors are editors of the *JABFM*.

Primary care clinicians in New England identified 4 major areas of COVID-19-era concerns: (1) bureaucracy, (2) leadership, (3) telehealth and patient care, and (4) clinician work life.[11] Family physician practices have made many adjustments as a result of the COVID-19 pandemic.[12] For example, the increase in telehealth is well known, but the authors identified many other types of changes that offices made. Some of the changes are likely to persist post-pandemic, and others are not. Interestingly, the data were drawn from the American Board of Family Medicine physician recertification reporting.

In the fascinating article, health care workers were surveyed early and 1 year into the pandemic, showing that the personal toll is both obvious and persisting.[13] Of the various health care workers, residents and nurses interacted with more patients who died of COVID-19 than other groups. Not surprisingly, emergency and critical care and female health care workers experienced the most patient deaths. Many experienced periods of quarantine. The authors provide additional interesting insights.

The COVID-19 pandemic drove people out of workplaces and into their homes, decreasing their direct interaction with others. What has that meant for the amount of physical exercise? It seems obvious there was less group and team exercise. Did outdoor or home exercise make up for this? And what happened to patient's weight? Byrne et al[14] surveyed patients of a university family medicine office to describe these effects.

Common Problem Insights and Solutions

Hypertension frequently tops lists of most common medical reasons for visits. Yet, as noted by Green et al,[15] multiple types of family medicine office providers differ on how blood pressure should be measured and diagnosed, and at what readings hypertension should be treated. Some prescribing providers did not know about 24-hour ambulatory blood pressure monitoring and/or the recommendations from the United States Preventive Services Task Force (USPSTF) regarding the use blood pressure measurements outside of the office for diagnosis. This is a wake-up call to ensure all clinical staff are updated and consistent.

Of almost 5000 patients at risk for obstructive sleep apnea (based on 3 classic risk factors) in multiple family medicine practices in Michigan, about a third received testing for sleep apnea.[16] Interestingly, the incidence of obstructive sleep apnea is unknown – yes, we know it is common, but just how common is unclear. Studies show positive outcomes from treatment, including lower death rates. In a 2017 statement, the USPSTF did not find enough evidence to recommend screening, but perhaps that will change.

Coordination for cancer survivorship care is poor.[17] Oncologists and family physicians do not agree on whether it occurs, and who should do what. Oncologists report more attempts at written coordination than is recognized by primary care. Further, many patients do not follow-up with oncology. Improving care will require changes by all 3—primary care, oncology, and patients.

As adults are increasingly diagnosed with type 2 diabetes at a younger age, family physicians are challenged with helping them navigate the world of chronic disease and self-management. Gopalan et al[18] shares findings from a qualitative study that identifies life stage-related facilitators and barriers to self-management among younger adults. Among lessons for family physicians is a key factor that will sound familiar: family matters.

This issue also includes a clinical review on plantar dermatosis.[19]

Opioids

As the leading clinical specialty caring for patients taking chronic opioid medications, it is important to know what actions can decrease unnecessary opioid use. As a result of an innovative Oregon Medicaid back/neck pain coverage, almost half of the patients were no longer on opioids after 18 months, primarily through gradual dose reductions, and many others were on lower doses. Read about the success and details of the program in Muench et al.[20] As a further measure, Messinger and coauthors[21] argue that the US should decriminalize buprenorphine based on both its safety and the importance to decreasing the negative outcomes of the opioid epidemic.

Thought Provoking

"You can call me Doctor and Friend"[22] is a very accurate title for the experience and suggestions from a rural family physician on the sense of isolation and conflicting thoughts from being called 'doctor' even in personal or interpersonal situation inside and outside of work.

Before medical school is the key time to ensure interest in family medicine to increase our proportion of

total physicians, which is important to the overall health of the nation. Those students interested in family medicine before coming into medical school had the highest likelihood of becoming family physicians.[23] Findings reflect more than a decade of data (1991 to 2010) from the 2047 graduates of Michigan State University College of Human Medicine, a school with a long-standing emphasis on primary care.

Schacht et al[24] provide a summary of 2 decades of malpractice cases for 1 Department of Family Medicine. Faculty attendings were almost always named in the suits, and residents about a quarter of the time. Obstetric cases were the costliest, cancer-related diagnoses were most common, and pediatric cases most uncommon. The Peer Review Committee that determined whether the care involved met standard of care were highly predictive of payouts. Of note, the missed diagnoses were significantly different from a study from 2010,[25] which had missed myocardial infarction as the most common case with payouts.

Appropriate clinical quality measures should be useful to reduce harms and costs of health care and improve the quality of care. However, these measures have not been evaluated adequately. Drabkin et al[26] tackle this issue, defining 10 criteria for measurement appropriateness, and thus providing a method to improve performance measurement in a "systematic, reproducible, and widely accepted manner." Quite a challenge.

To see this article online, please go to: http://jabfm.org/content/35/2/215.full.

References

1. Jetty A, Hyppolite J, Eden AR, Taylor MK, Jabbarpour Y. Underrepresented minority family physicians more likely to care for vulnerable populations. J Am Board Fam Med 2022;35:223–224.
2. Shabu T, Espinoza AM, Manning S, Cardarelli R, Fulda KG. Patient research interest differences by gender and race/ethnicity: a North Texas primary care practice-based research network (NorTex) study. J Am Board Fam Med 2022;35:225-234.
3. Cramer J. A linguist's perspective on the American Board of Family Medicine's differential item functioning panel. J Am Board Fam Med 2022;35:387–389.
4. Ulrich IP, Harless C, Seamon G, et al. Implementation of transgender/gender non-binary care in a family medicine teaching practice. J Am Board Fam Med 2022;35:235–243.
5. Martinez B, Huh J, Tsui J. Validating the group-based medical mistrust scale with English and Spanish speaking Latino parents of adolescents. J Am Board Fam Med 2022;35:244–254.
6. Ali AS, Khan M, Ortega D, Jaffery S, Lamerato LE, Budzynska K. Prescription patterns of novel antihyperglycemic medications. J Am Board Fam Med 2022;35:254–264.
7. Razon N, Gottlieb L. Content analysis of transportation screening questions in social risk assessment tools: are we capturing transportation insecurity?. J Am Board Fam Med 2022;35:400–405.
8. Chicoine C, Hickey EE, Kirschner KL, Chicoine BA. Ableism at the bedside: people with intellectual disabilities and COVID-19. J Am Board Fam Med 2022;35:390–393.
9. Claus LE, Leland EM, Tai KY, et al. Olfactory loss and beyond: a practical review of chemosensory dysfunction. J Am Board Fam Med 2022;35:406–419.
10. Boness CL, Nelson M, Douaihy AB. Motivational interviewing strategies for addressing COVID-19 vaccine hesitancy. J Am Board Fam Med 2022;35:420–427.
11. Sullivan EE, Breton M, McKinstry D, Phillips RS. COVID-19's perceived impact on primary care in New England: a qualitative study. J Am Board Fam Med 2022;35:265–273.
12. Price DW, Eden AR, Baxley EG, Williamson A, Newton WP. Practice adjustments made by family physicians during the COVID-19 pandemic. J Am Board Fam Med 2022;35:274–283.
13. Yamane D, Zarabian K, Devine K, et al. Hospital-based healthcare worker perceptions of personal risk related to COVID-19: one year follow-up. J Am Board Fam Med 2022;35:284–294.
14. Byrne NW, Parente DJ, Yedlinsky NT. Impact of the COVID-19 pandemic on exercise habits among US primary care patients. J Am Board Fam Med 2022;35:295–309.
15. Green BB, Anderson ML, Ehrlich K, et al. Blood pressure checks for diagnosing hypertension: health professionals' knowledge, beliefs, and practices. J Am Board Fam Med 2022;35:310–319.
16. Arsic B, Zebic K, Sajid A, et al. Assessing the adequacy of obstructive sleep apnea diagnosis for high-risk patients in primary care. J Am Board Fam Med 2022;35:320–328.
17. Doescher MP, Nagykaldi Z, Zhao YD, Dwyer K. Oncology and primary care clinician views on cancer survivorship care: mind the gap. J Am Board Fam Med 2022;35:329–340.
18. Gopalan A, Blatchins MA, Xu KK, et al. All in the family: a qualitative study of the early experiences of adults with younger onset type 2 diabetes. J Am Board Fam Med 2022;35:341–351.
19. Rasner CJ, Kullberg SA, Pearson DR, Boull CL. Diagnosis and management of plantar dermatoses. J Am Board Fam Med 2022;35:435–442.
20. Muench J, Hoopes M, Mayhew M, et al. Reduction of long-term opioid prescribing for back pain in

community health centers after a Medicaid policy change. J Am Board Fam Med 2022;35:352–369.

21. Messinger JC, Chukka A, Boyd JW. Against our instincts: decriminalization of buprenorphine. J Am Board Fam Med 2022;35:394–397.
22. Ellis J. You can call me "doctor" and "friend". J Am Board Fam Med 2022;35:443–444.
23. Edwards-Johnson J, Lee Y, Wendling A, Patel B, Phillips J. Predictors of primary care practice among medical students at the Michigan State University College of Human Medicine. J Am Board Fam Med 2022;35:370–379.
24. Schacht K, Furst W, Jimbo M, Chavey WE. A malpractice claims study of a family medicine department: a 20-year review. J Am Board Fam Med 2022;35:380–386.
25. Flannery FT, Divya Parikh P, Oetgen WJ. Characteristics of medical professional liability claims in patients treated by family medicine physicians. J Am Board Fam Med 2010;23:753–61.
26. Drabkin A, Adler RN, Altman W, Ehrlich AM, Agnoli A, Alper BS. Clinical quality measures: a challenge for—and to—family Physicians. J Am Board Fam Med 2022;35:427–434.