## Influences on Scope of Practice: Not Only Population Size

**TO THE EDITOR:**

We read with great interest the article "Rural Curricular Guidelines Based on Practice Scope of Recent Residency Graduates Practicing in Small Communities" by Dr Skariah and colleagues.[1] Considering the lack of information about medical graduates' scope of practice, we highly appreciate the authors' endeavor to establish evidence for its impact on the quality of graduate medical education. However, we would like to point out two issues with the paper.

First, scope of practice in rural areas is different from that in urban areas in family medicine.[2] Since scope of practice should reflect community needs, factors affecting local health care must be taken into consideration. A recent study highlighted, in part, such factors. In this study, 67 items were identified as risk factors for disease and injury.[3] This demonstrates that factors other than population influenced the incidence of diseases and injuries. The items include dietary factors, physical inactivity, and alcohol, tobacco, and drug use. Moreover, approximately 30% of scope of practice variation was attributable to geographic variables including distance to large hospitals, community size, and region. Among these three variables, distance to a large hospital had the greatest impact on physicians' scope of practice.[4] Thus, rural areas as defined by the authors solely based on population size could be heterogeneous in terms of disease structures and medical needs. We think it is reasonable to consider factors such as distance to large hospitals and other geographic variables and community needs in further studies.

Second, soon after graduation from residency, family medicine specialists are said to have a wider scope of practice compared to experienced family physicians, particularly in prenatal care, inpatient care, nursing home care, home visits, and women's health procedures.[5] Interestingly, work environments including job location influenced scope of practice less. One suggested hypothesis was that residents were too aspirational and tended to overestimate their scope of practice, because "residents may be unlikely to report that they do not intend to provide a service they have spent 3 years learning." We would suggest for future research a similar study on the scope of practice of experienced specialists.

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**Daisuke Kato, MD**
Department of Education and Research in Family and Community Medicine
Mie University Graduate School of Medicine, Tsu City, Japan

**Kenya Ie, MD, PhD, MPH**
Department of General Internal Medicine
St Marianna University School of Medicine, Miyamae-ku, Japan

**Hideki Wakabayashi, MD, PhD, MA**
Department of Education and Research in Family and Community Medicine
Mie University Graduate School of Medicine, Tsu City, Japan

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## Creating Health Equity Curricula

**TO THE EDITOR:**

We read with great interest the heroic work of Noriea et al in developing a multifaceted health disparities curriculum.[1] Having taught and researched in this area for many years, we would add the following thoughts for others developing these important curricula:

1. Balance teaching about the problem (disparities) with teaching about solutions (paths to health equity). Disparities are pervasive and persistent, but not inevitable. A number of communities have made significant progress on reducing or eliminating specific health disparities.[2,3]
2. Balance the understanding of personal choices and individual health behaviors with the context in which these choices are made. Health behaviors are greatly influenced by the social, economic, cultural, and physical environment, but also positively influenced by knowledge sharing, asset identification, resource allocation, community cohesiveness, and interpersonal connectivity.
3. Paint with a broad brush the full range of determinants of health, including environmental factors, sociopolitical and structural inequities, cultural, race, and gender bias factors, etc that influence health. Promote a lens of equity and empowerment rather than blaming the person for his/her own poverty, discrimination, or limited neighborhood resources. Teach strategies for overcoming systemic barriers.
4. Maintain the relentlessly positive spirit we have learned from leaders of social change and civil rights movements, who also worked in the face of seemingly overwhelming odds.[4] Avoid a sense of inevitability or powerlessness, and balance the backward look at risk factors or determinants with a forward-looking search for effective paths to achieving health equity. Social and environmental determinants are not deterministic, but can be a starting place of hope—where individuals themselves can become agents of change by understanding the context and upstream drivers of disparities, and then working to achieve positive change in partnership with community coalitions.
5. Balance the deficit-model of risk factors with an asset-based model that recognizes community strengths and sources of resiliency. People, communities, and systems have the ability to overcome inequity as we value all people, show love in both substance and heart, and provide resources according to need.[5] In the clinic, this also means teaching residents to assess patient strengths, resources, and resilience, not just unhealthy behaviors or unmet needs. Within a residency program, a longitudinal activity-based curriculum that substantially moves the needle on reducing or eliminating a specific health (or health care) disparity would teach residents that measurable, positive change is possible.
6. Break down the clinic wall as a boundary between what clinicians do and what drives community health outcomes. Social determinants, health behaviors, health care, and health outcomes are all tied together in complex, multidirectional associations. We can teach specific skills of community-oriented primary care, community health promotion, and asset-based community-driven development (ABCD),[6] and we can teach residents to work on interdisciplinary teams that cross the clinic wall as a boundary (eg, care management teams of nurses, social workers, peer counselors, and *promotoras* or community health workers).
7. Finally, engage patients and community advocates to teach us their history, their lived experience, their realities, and their vision of positive solutions in which we might be invited to take part. Various stakeholders remind us, "Nothing About Us Without Us." Empowerment, engagement, advocacy, and partnership with community members in shared decision-making that is culturally relevant and community-owned is essential for building longer-term sustainable change.

Exercises, readings, and experiential learning must reflect this balance of complexity and hope. Again, we congratulation the authors on the great work accomplished in building this curriculum. We hope that many more across the nation take up the challenge of preparing the next generation of health professionals to move us ever closer to health equity!

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**George Rust, MD, MPH, FAAFP, FACPM**
Department of Behavioral Sciences and Social Medicine
Florida State University College of Medicine

**Joedrecka S. Brown Speights, MD, FAAFP**
Department of Family Medicine and Rural Health
Florida State University College of Medicine

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## Authors' Response to "Creating Health Equity Curricula"

**TO THE EDITOR:**

We agree with and appreciate the thoughtful response of Dr Rust and Dr Brown Speights to our article "Development of a Multifaceted Health Disparities Curriculum for Medical Residents." We offer thanks to them for their enhancement of the conversation regarding how best to teach this important topic to resident learners.

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**Ashley H. Noriea, MD, MAPP**
Section of General Internal Medicine
University of Chicago

**Nicole Redmond, MD, PhD, MPH**
National Heart, Lung, and Blood Institute
National Institutes of Health

**Rebekah A. Weil, MD**
Division of General Internal Medicine
Oregon Health and Sciences University

**William A. Curry, MD, FACP**
Division of General Internal Medicine
University of Alabama School of Medicine

**Monica E. Peek, MD, MPH, MSc**
MacLean Center for Clinical Medical Ethics
University of Chicago

**Lisa L. Willett, MD, MACM, FACP**
University of Alabama at Birmingham