LETTERS
TO THE EDITOR

The Context of Simple Rules

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The special article by Dr Etz et al, "Simple Rules that Guide Generalist and Specialist Care" is a gem.[1] It inspired me to reflect in the wee hours this morning on the context of these simple rules. As the authors acknowledge, both sets of rules are used by all clinicians under different contexts, although specialists and generalists often differ in how frequently they adopt each set of rules.

Simple rules, whether those guiding avian or human social behavior, are triggered by context. The frequency and thresholds for threat-based flight and subsequent flocking differ by species and geographical context.[2] Similarly, a sprained ankle in a healthy teenager might evoke the first set of rules in contrast to caring for a person with multiple chronic illnesses.

Which set of rules are adopted reflect context related to models of care and training. Specialists are often trained using disease models that adopt a medicotechnical approach based on the first set of rules. Generalists are more often trained to adopt a person-centered model in the context of a long-term, caring relationship. These models and training context shapes each group's approach to care and the corresponding expectations by patients regarding which set of rules will be applied.

Context enables these rules during patient care. Recognizing, prioritizing, and personalizing are best accomplished in the context of a longitudinal relationship that promotes health, healing, and meaningful interpersonal connection. Patients' emotions (eg, fear, anxiety, uncertainty), can trigger attachment behavior reflecting long-standing meaningful relationships,[3] just as perceived threat by birds elicits flight and refuge in the flock.

Interestingly, the second set of rules are highly contextually dependent. When and how a clinician recognizes, prioritizes, and personalizes care is inherently contingent on the patient, the relationship, the problems, and the context of the visit.

Our health care system undervalues the second set of rules and funds delivery models that favor the first set.[4] Yet, the COVID-19 pandemic has reminded us that it is the second set of rules that helps vaccine-hesistant patients make the right choice for themselves, their families, and their communities.[5]

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Kevin Fiscella, MD, MPH
Department of Family Medicine, University of Rochester Medical Center
Rochester, NY

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The Forgotten Underrepresented Minorities: A Call for Data Disaggregation

TO THE EDITOR:

In the July-August 2021 issue of *Family Medicine*, Drs Jabbarpour and Westfall discussed the importance of racial diversity in the family medicine workforce.[1] I applaud the authors' commentary highlighting that the field of family medicine can address racial inequalities in our patient population by addressing structural racism and by promoting diversity and inclusion in residency training. One way to continue our progress is to advocate for racial data disaggregation.

Data disaggregation is the breakdown of data into detailed subgroups. This can reveal inequalities that may not have been fully reflected in the aggregated data. Data inequity is a form of structural racism, as it ignores vulnerable subgroups and denies allocation of

much-needed resources. This is especially true in the case of Asian Americans.

In most racial/ethnic data collections, Asian Americans are seen as a monolith, when the reality is that they encompass a diverse array of nationalities, languages, immigration histories, and socioeconomic backgrounds. For instance, Japanese Americans have lower poverty rates than White Americans, while Hmong, Khmer, Laotian, and Vietnamese Americans have higher poverty rates.[2] When Asian American data are aggregated, the conclusions misleadingly suggest that Asian Americans as a singular population are thriving, perpetuating the harmful myth on Asian Americans being the model minority, where they are assumed to be doing better than other minority groups.[3,4]

Consequently, Asian American physicians are excluded from the designation of underrepresented minority (URM) in medicine as they make up 7% of the nation's overall population, yet 17% of active physicians, implying that Asian American physicians are the overrepresented minority. However, data disaggregation would reveal that while Filipinos make up 18% of the nation's Asian American population, they made up only 4.3% of the Asian American medical school applicants in 2019. Additionally, Laotians, Indonesians, and Cambodians altogether made up only 0.5% of the Asian American applicants.[5,6] I am only able to provide breakdown examples of the medical school applicants as disaggregated data of active Asian American physicians are not even collected.

As the original authors mentioned, patient/provider racial concordance leads to improved patient-provider communication, medical adherence, and patient satisfaction.[1] With all the nuances within a large racial categorization, data disaggregation allows us family physicians to see and serve marginalized communities that may have been invisible otherwise. Only when we begin to collect this data can we recruit and train family physicians that look like the diverse patients we serve.

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Oanh Truong, MD
University of Pittsburgh Medical Center (UPMC) St Margaret Family Medicine Residency Program
Pittsburgh, PA

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