2024, Volume 56, Issue 10, 682-683, e-ISSN 1938-3800

Family Medicine

BOOK REVIEW

Health Equity: A Guide for Clinicians, Medical Educators & Healthcare Organizations

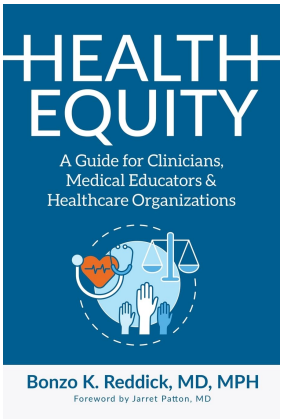
Kenneth W. Lin, MD, MPH

AUTHOR AFFILIATION:

Family Medicine Residency, Lancaster General Hospital, Lancaster, PA

HOW TO CITE: Lin KW. Health Equity: A Guide for Clinicians, Medical Educators & Healthcare Organizations. *Fam Med.* 2024;56(10):682-683.
doi: 10.22454/FamMed.2024.871711

PUBLISHED: 9 August 2024



Book Title: Health Equity: A Guide for Clinicians, Medical Educators & Healthcare Organizations

Author: Bonzo K. Reddick, MD, MPH

Publication Details: Purposely Created Publishing Group, 2024, 255 pages, $25, paperback

In the past decade, medical education has evolved from simply teaching facts about health disparities (ie, statistics demonstrating that certain groups of people have a greater burden of health conditions than others) to advocating for health equity (ie, identifying and remedying the root causes to reduce or eliminate disparities).[1] The unequal health effects of the COVID-19 pandemic and the antiracist demonstrations in the summer and fall of 2020 accelerated this trend. Bonzo Reddick, MD, MPH, a family physician and former associate dean of Diversity, Equity, & Inclusion at Mercer University School of Medicine, found himself in demand as a speaker as medical schools added health equity content to their curricula. Recognizing that many faculty members had not taught this subject before, Reddick wrote *Health Equity: A Guide for Clinicians, Medical Educators & Healthcare Organizations*. This book discusses health disparities associated with racism and race-based medical decision-making, sexism, sexual and gender minority status, religious and cultural intolerance, housing instability, physical and intellectual disabilities, obesity, rural health, and substance use disorders.

Health inequities, the author explains, are disparities "linked to systematic discrimination or exclusion due to societal obstacles. Health disparities are differences, while health inequities are inexcusable differences" (p. 2). Although discrimination may be overt, more commonly it occurs not due to the bad behavior of individuals, but to structural obstacles such as inadequate sick leave, restrictive eligibility criteria for public health insurance, and implicit bias from medical training. For example, the widespread misperception among health professionals that women who self-identify as lesbians are not at risk for cervical cancer contributes to low rates of Pap smears being performed in this population.

Beginning with the second chapter, each follows a consistent structure. The chapter starts with an anecdote (eg, "Bungle of the Month") in which Reddick's own implicit biases led to a gaffe regarding a member of a disadvantaged population. For example, he once assumed that a teenaged Black male who was absorbed with his smartphone must have poor grades in school and be uninterested in science when, in fact, the patient was a straight-A student who wrote computer code on a regular basis. The anecdote is followed by a description of the major disparities experienced by that group and the supporting literature. The chapter then presents a knowledge, attitudes, and skills framework for improving health equity. Finally, a case or an activity is included to engage learners in reviewing the concepts discussed. This increasingly familiar structure, combined with strategically placed figures and illustrations, makes *Health Equity* an engrossing read. End notes list key references supporting the conclusions of each chapter and may be used for more in-depth reading.

My favorite chapter (Chapter 4) discussed the clinical misuse of race and ethnicity as proxies for biological differences. Health care algorithms with these inputs have been observed to perpetuate or exacerbate disparities.[2] In a prior editorial, Reddick noted that according to the pooled cohort equations, being Black increased his risk of having a cardiovascular event more than smoking did in a White male with otherwise identical

risk factors.[3] In the book, he builds on that example by deconstructing race-based beliefs held by generations of clinicians and, until recently, reiterated in practice guidelines and prognostic tools: "Angiotensin-converting enzyme inhibitors do not work in Black people" (p. 65); Black people have more muscle mass than other races, so a higher creatinine level does not indicate chronic kidney disease; because they have a lower calculated fracture risk, screening and treating for osteoporosis is less important for Black women. Most importantly, "race-based approaches to medicine reinforce a system that assumes biological causes of health inequities, which can cause us to ignore the social determinants of health that are the true drivers for racial disparities in health outcomes" (p. 68).

This relatively compact text is an essential resource for preclinical courses in population health and family medicine clerkships and residency programs. Beyond academia, it also could support creating clinical environments that are antiracist and welcoming to persons of all identities and backgrounds.[4] In a reactionary era where diversity, equity, and inclusion initiatives at many educational institutions have been banned or devalued, health care in America would be better off if every clinician, instructor, and health system leader would read *Health Equity*.

REFERENCES

1. Henry TL, Rollin FG, Olakunle OE. How to create a diversity, equity, and inclusion curriculum: more than checking a box. *Ann Fam Med.* 2024;22(2):154-160.
2. Siddique SM, Tipton K, Leas B. The impact of health care algorithms on racial and ethnic disparities: a systematic review. *Ann Intern Med.* 2024;177(4):484-496.
3. Reddick B. Fallacies and dangers of practicing race-based medicine. *Am Fam Physician.* 2021;104(2):122-123.
4. Brown J, Beesley R. It's time: six steps to creating an anti-racist clinic. *Fam Pract Manag.* 2023;30(4):23-26.