17. Dehmer SP, Maciosek MV, LaFrance A, Flottemesch TJ. Health benefits and cost-effectiveness of asymptomatic screening for hypertension and high cholesterol and aspirin counseling for primary prevention. *Ann Fam Med.* 2017;15(1):23-36.
18. Maciosek MV, Dehmer SP, Xu Z, et al. Health benefits and cost-effectiveness of brief clinician tobacco counseling for youth and adults. *Ann Fam Med.* 2017;15(1):37-47.
19. Satcher D. Preventive interventions: an immediate priority. *Ann Fam Med.* 2017;15(1):8-9.
20. Isham G, Sanchez E, Jones W, Teutsch S, Woolf S, Haddix A. Prevention priorities: guidance for value-driven health improvement. *Ann Fam Med.* 2017;15(1):6-8.
21. O'Connor PJ, Sperl-Hillen J, Kottke TE, Margolis K. Strategies to prioritize clinical options in primary care. *Ann Fam Med.* 2017;15(1):10-13.
22. Saver BG, Luckmann R, Cutrona S, et al. Persuasive interventions for controversial cancer screening recommendations: testing a novel approach to help patients make evidence-based decisions. *Ann Fam Med.* 2017;15(1):48-55.
23. Johansen ME. Measuring outcomes: lessons from the world of public education. *Ann Fam Med.* 2017;15(1):iii.
24. Saultz A, Saultz JW. Measuring outcomes: lessons from the world of public education. *Ann Fam Med.* 2017;15(1):71-76.
25. Ankuda C, Petterson SM, Wingrove P, Bazemore AW. Regional variation in primary care involvement at the end of life. *Ann Fam Med.* 2017;15(1):63-67.
26. Ungar T. Neuroscience, joy, and the well-infant visit that got me thinking. *Ann Fam Med.* 2017;15(1):80-83.
27. Volkmann ER. Silent survivors. *Ann Fam Med.* 2017;15(1):77-79.
28. Umaretiya P, Oberhelman S, Cozine E, Maxson J, Quigg S, Thacher TD. Maternal preferences for vitamin D supplementation in breastfed infants. *Ann Fam Med.* 2017;15(1):68-70.
29. Rittenhouse DR, Ramsay PP, Casalino LP, McClellan S, Kandel ZK, Shortell SM. Increased health information technology adoption and use among small primary care physician practices over time: a national cohort study. *Ann Fam Med.* 2017;15(1):56-62.

EDITORIAL

Perspectives in Primary Care: Family Medicine in a Divided Nation

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On November 8, 2016, family physicians went to work across the United States caring for patients. Some patients wore caps emblazoned "Make America Great Again" and others had buttons declaring "I'm With Her." As on any other day, the task was to care for each patient with respect and dignity. On November 9, the country awoke to a new president-elect. Half of voters were excited by the promise of a new administration leading the nation toward a greater future, and half were fearful of what lay ahead.

We do not pretend that all family physicians share the same political ideology. But we do believe that in a nation seemingly so at odds, family medicine can help heal the divide. The months preceding the election exposed many wounds. Unemployed and underemployed workers in the Rust Belt decried the departure of well-paying jobs. Videos streamed images of police officers killing unarmed African American men, provoking public outrage and movements to confront institutional racism. Dallas, Baton Rouge, and other communities mourned the premeditated killing of unsuspecting police officers. Immigrants found heightened cause to fear that their families would be wrenched apart by deportations. Individuals denounced the rising cost of insurance in an era of supposed affordable care. A fractious campaign culminated in an election revealing deep schisms based on geography, race, ethnicity, social class, and religion. Whereas 88% of African Americans and two-thirds of Latinos and Asians voted for Hillary Clinton, exit polls indicate that 58% of whites voted for Donald Trump.[1] Support for Trump was particularly high among whites without a college degree and among residents of rural communities. Highly educated city dwellers strongly preferred Clinton.

Although pundits portrayed the election as red state bigots versus entitled blue state elitists, family physi-

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cians see a more complex portrait of the nation's diverse communities. Family doctors practice in communities reflecting the geographic distribution of the nation's overall population more than physicians in other specialties.[2] They work on the front lines of US health care in remote rural towns, inner cities, and sprawling suburbs, caring for patients across a spectrum of social classes, races, and political persuasions. The work of primary care involves listening to patients' stories, which affords insight into the complex mix of kindness, prejudice, generosity, frailty, decency, pain, and courage in every person. The task of family medicine is to partner with patients, families, and communities, acknowledging all their complexities, vulnerabilities, and strengths, to improve the nation's health and well-being.

What does it mean to be a healthy society? Rarely has this question felt so urgent, and the answer so fragile. A powerful first step family physicians can take is to reject the false dichotomy that characterizes the nation as having a problem of *either* economic hardship *or* racial injustice. We have both. The United States lags behind other industrialized nations in indicators of population health. Much of the poor overall health of Americans is rooted in the underlying social and environmental conditions that powerfully influence health and illness.[3] Since the 1970s, income inequality in the United States rose to levels not seen in America for the last century.[4] These vulnerabilities are reflected in public health statistics showing a 3-year advantage in life expectancy for white Americans compared with African Americans.[5] In addition, death rates among middle-aged whites increased from 1999 to 2013 after many decades of steady declines, with less-educated whites experiencing the largest increase.[6] The past year exposed the grievances of many working-class Americans about a globalized, technology-driven economy that has left them behind and the outcry of people nationwide that Black Lives Matter.

The journey to a healthier nation cannot progress well over a terrain fractured by divisiveness and distrust. Family physicians have a duty to heal divisions and build bridges between the diverse communities in which they live and practice.

We propose that family physicians commit to 4 actions:

1. Address Bias

Patient-centered care requires recognizing and valuing every individual as unique. The election highlighted an abundance of misassumptions, biases, and tendencies to stereotype people across the political spectrum. Unconscious bias tests show that physicians hold implicit prejudices that influence the care they provide.[7] We urge all family physicians to explore the roots of their bias by examining their privilege, fostering workplace conversations to address discrimination, and challenging institutions and policies that propagate implicit bias.

2. Model Inclusivity

Family medicine practices should be welcoming, inclusive, and safe places for patients, staff and trainees. Insisting on zero-tolerance for hostile work environments is not political partisanship. Modeling inclusivity also requires cultivating clinician leaders from diverse backgrounds underrepresented in our ranks. More than half of US medical students come from the wealthiest 20% of US households, and the number of African-American male students matriculating to US medical schools has declined from 1978 to 2014.[8,9] We need to do better.

3. Attend to the Social Determinants of Health

A growing body of literature supports the feasibility and effectiveness of deploying interventions in the primary care clinical setting to address social determinants.[10,11,12] Primary care practices should identify pragmatic steps to link patients to community resources. Health care payers implementing population-based payment models should support family physicians adopting these interventions. Medical professional organizations have affirmed that physicians must understand and address poverty to effectively care for their patients,[13,14] but we need to further emphasize community strategies to tackle the "causes of the causes" driving poor health.[15]

4. Advocate for Health

Family medicine can lead by emphasizing health in a world of competing political priorities. This means advocating for patients beyond the clinic with civic institutions such as faith organizations, community associations, social clubs, and advocacy groups. As the nation debates the future of the Affordable Care Act, immigration policy, the federal tax code, and environmental regulations, family physicians must ensure that the agenda for our nation's future includes a healthier and more equitable America.

To read or post commentaries in response to this article, see it online at http://www.annfammed.org/content/15/1/4.

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References

1. Huang J, Jacoby S, Strickland M, Lai KKR. Election 2016: exit polls. The New York Times. http://www.nytimes.com/interactive/2016/11/08/us/politics/election-exit-polls.html. Published Nov 8, 2016. Accessed Nov 21,2016.

2. Agency for Healthcare Research and Quality. Primary care workforce facts and stats No. 3: prevention & chronic care program. AHRQ Pub No 12-P001-4-EF. http://www.ahrq.gov/sites/default/files/publications/files/pcwork3.pdf. Published Jan 2012. Accessed Nov 21, 2016.
3. Institute of Medicine and National Research Council. *U.S. Health in International Perspective: Shorter Lives, Poorer Health.* Washington, DC: The National Academies Press; 2013. doi:10.17226/13497.
4. Saez E, Zucman G. Wealth inequality in the United States since 1913: Evidence from capitalized income tax data. *Q J Econ*. 2016;131(2):519-578.
5. Egerter S, Braveman P, Pamuk E, et al. *America's Health Starts with Healthy Children: How Do States Compare?* Washington, DC: Robert Wood Johnson Foundation Commission to Build a Healthier America; 2008.
6. Case A, Deaton A. Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century. *Proc Natl Acad Sci U S A*. 2015;112(49):15078-15083.
7. Chapman EN, Kaatz A, Carnes M. Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities. *J Gen Intern Med*. 2013;28(11):1504-1510.
8. Jolly P. AAMC analysis in brief: diversity of U.S. medical students by parental income. Association of American Medical Colleges. https://www.aamc.org/download/102338/data/aibvol8no1.pdf. Published 2008. Accessed Nov 24, 2016.
9. Association of American Medical Colleges. Altering the course: black males in medicine. Association of American Medical Colleges. http://members.aamc.org/eweb/upload/Black_Males_in_Medicine_Report_WEB.pdf. Published 2015.
10. Gottlieb LM, Hessler D, Long D, et al. Effects of social needs screening and in-person service navigation on child health: a randomized clinical trial. JAMA Pediatr. 2016;170(11):e162521.
11. Lindau ST, Makelarski J, Abramsohn E, et al. CommunityRx: a population health improvement innovation that connects clinics to communities. *Health Aff (Millwood)*. 2016;35(11):2020-2029.
12. DeVoe JE, Bazemore AW, Cottrell EK, et al. Perspectives in primary care: a conceptual framework and path for integrating social determinants of health into primary care practice. *Ann Fam Med*. 2016;14(2):104-108.
13. AAP Council on Community Pediatrics. Poverty and child health in the United States. *Pediatrics*. 2015;137(4):e20160339.
14. Czapp P, Kovach K. Poverty and health – the family medicine perspective (position paper). American Academy of Family Physicians. http://www.aafp.org/about/policies/all/policy-povertyhealth.html. Accessed Nov 15, 2016.
15. Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. *Public Health Rep*. 2014;129(Suppl 2):19-31.

EDITORIALS

Prevention Priorities: Guidance for Value-Driven Health Improvement

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The National Commission on Prevention Priorities released its first ranking of clinical preventive services in 2001.[1] A rigorous methodology was developed that allowed for comparisons to be made across clinical preventive services on the basis of health benefit (improved length and quality of life) and value (cost-effectiveness).[2] The methodology was applied to evidence-based interventions that had received A or B ratings from the US Preventive Services Task Force (USPSTF), as well as key recommendations from the Advisory Commission on Immunization Practices (ACIP).

In this issue of the *Annals of Family Medicine*, Maciosek et al share the 2016 ranking of clinical preventive services, which include 28 of the current USPSTF

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