

# Letters to the Editor

## Medical Content Should Be Equitable and Inclusive of Diverse Populations

**To the Editor:** I am writing to bring your attention to the need for more racially inclusive language and equity-driven content in *American Family Physician (AFP)*. For example, I was struck by the noninclusivity of one sentence in the article on vitamin D screening and supplementation in the February 15, 2018, issue.<sup>1</sup> In the context of describing recommended dietary allowances of vitamin D, the authors wrote, “Sufficient sun exposure to produce a light-pink skin hue (one minimal erythema dose) is equivalent to 20,000 IU of oral vitamin D.”<sup>1</sup> By writing about light-pink skin hue without qualifying the sentence, the authors implied that light pink is the only skin hue relevant to the reader. I suggest that sentences that apply *only to a portion* of the population be preceded by qualifiers, such as, “For those with light skin color, [...]” The sentence should then be followed by a statement relating the effects of sun exposure on vitamin D levels of people with darker skin colors.<sup>2</sup>

The American Academy of Family Physicians has made efforts to reduce health disparities by launching the EveryONE project, which seeks to address the social determinants of health at the home and neighborhood levels (<https://www.aafp.org/patient-care/social-determinants-of-health/cdhe/everyone-project.html>). Eliminating health disparities requires a multipronged and multilevel approach involving every institution and sector of society. As one component, *AFP* is well positioned to help readers address inequities in our one-on-one patient encounters

through improving the quality of care that we provide to marginalized groups. I have three suggestions:

1. Provide Continuing Medical Education (CME) content that uses inclusive language to guide care for all of our diverse patients. Language used in the journal should be inclusive of all skin colors, genders, ranges of able-bodiedness, and socioeconomic backgrounds that our patients represent.

2. Highlight the gaps in literature when research studies underrepresent marginalized groups. Consider making it a criterion for authors of *AFP* to critically apply a health equity lens and to make it transparent when a content area is lacking in generalizability.<sup>3</sup>

3. Acknowledge and address the impact of implicit bias. One factor that contributes to health care disparities in the United States is implicit racial biases that affect physician-patient interactions and influence medical decision-making.<sup>4</sup> One step toward reducing implicit biases is to make physicians aware of their susceptibility to biases so that engrained habits can be actively and intentionally dismantled.<sup>5</sup> Wherever evidence for implicit biases negatively affecting care is available, *AFP* review articles can draw upon existing work and propose specific strategies to disrupt the perpetuation of biases from one generation of physicians to the next.<sup>6</sup>

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## References

1. LeFevre ML, LeFevre NM. Vitamin D screening and supplementation in community-dwelling adults: common questions and answers. *Am Fam Physician*. 2018;97(4):254-260.
2. Khalid AT, Moore CG, Hall C, et al. Utility of sun-reactive skin typing and melanin index for discerning vitamin D deficiency. *Pediatr Res*. 2017;82(3):444-451.
3. Geller SE, Koch A, Pellettieri B, Carnes M. Inclusion, analysis, and reporting of sex and race/ethnicity in clinical trials: have we made progress? *J Womens Health*. 2011;20(3):315-320.
4. Dovidio JF, Fiske ST. Under the radar: how unexamined biases in decision-making processes in clinical interactions can contribute to health care disparities. *Am J Public Health*. 2012;102(5):945-952.
5. Byrne A, Tanesini A. Instilling new habits: addressing implicit bias in healthcare professionals. *Adv Health Sci Educ Theory Pract*. 2015;20(5):1255-1262.
6. Brooks KC. A piece of my mind. A silent curriculum. *JAMA*. 2015;313(19):1909-1910.

**Send letters** to [afplet@aaafp.org](mailto:afplet@aaafp.org), or 11400 Tomahawk Creek Pkwy., Leawood, KS 66211-2680. Include your complete address, e-mail address, and telephone number. Letters should be fewer than 400 words and limited to six references, one table or figure, and three authors.

**Letters submitted** for publication in *AFP* must not be submitted to any other publication. Possible conflicts of interest must be disclosed at time of submission. Submission of a letter will be construed as granting the AAFP permission to publish the letter in any of its publications in any form. The editors may edit letters to meet style and space requirements.

**This series** is coordinated by Kenny Lin, MD, MPH, Deputy Editor.

**In Reply:** Thank you for your insightful comments. We agree that it is essential that topics covered in *AFP* be inclusive of diverse populations. Given the concise nature of our articles, the emphasis is often on practical evidence-based points that are supported in the existing literature rather than highlighting knowledge gaps and making recommendations for further research. We can certainly be more mindful of noninclusive language, but here are the ways we've already been addressing diversity and health equity in the journal:

1. A recent editorial on social determinants of health highlighted the EveryONE Project resources (<https://www.aafp.org/afp/2019/0415/p476.html>).<sup>1</sup>

2. We've published articles on dermatologic conditions in skin of color (<https://www.aafp.org/afp/2013/0615/p850.html> and <https://www.aafp.org/afp/2013/0615/p859.html>)<sup>2,3</sup> and also a recent article on transgender care (<https://www.aafp.org/afp/2018/1201/p645.html>)<sup>4</sup> that has been acknowledged as an important resource in other articles ([https://www.medscape.com/viewarticle/909885#vp\\_1](https://www.medscape.com/viewarticle/909885#vp_1) [login required]).<sup>5</sup>

3. We have an *AFP* By Topic collection of content on Care of Special Populations, including historically marginalized groups (<https://www.aafp.org/afp/populations>).

4. We constantly reevaluate medical terminology to make sure that it's inclusive and does not promote implicit bias (e.g., "patient with opioid use disorder" instead of "opioid-dependent" or "opioid addict").

As always, we appreciate reader feedback and your interest in making *AFP* applicable to all of the patients family physicians care for.

**Sumi Sexton, MD**, Editor-in-Chief

**Kenny Lin, MD, MPH**, Deputy Editor

## References

1. Sherin K, Adebajo T, Jani A. Social determinants of health: family physicians' leadership role. *Am Fam Physician*. 2019;99(8):476-477.
2. Kundu RV, Patterson S. Dermatologic conditions in skin of color: part I. Special considerations for common skin disorders. *Am Fam Physician*. 2013;87(12):850-856.
3. Kundu RV, Patterson S. Dermatologic conditions in skin of color: part II. Disorders occurring predominantly in skin of color. *Am Fam Physician*. 2013;87(12):859-865.
4. Klein DA, Paradise SL, Goodwin ET. Caring for transgender-diverse persons: what clinicians should know. *Am Fam Physician*. 2018;98(11):645-653.
5. Citroner GW. Confronting transphobia in healthcare. *Medscape*. March 8, 2019. <https://www.medscape.com/viewarticle/909885> [login required]. Accessed April 24, 2019.

## Preoperative Nutritional Optimization in Older Patients Reduces Complications

**Original Article:** Preoperative Assessment in Older Adults: A Comprehensive Approach

**Issue Date:** August 15, 2018

**See additional reader comments at:** <https://www.aafp.org/afp/2018/0815/p214.html>

**To the Editor:** This article is deserving of praise for its thoroughness and recognition of an important issue. I wish to reiterate the significance of nutrition and offer practical recommendations for nutritional optimization.

More than 50% of older surgical patients are thought to have malnutrition.<sup>1</sup> Poor nutrition is associated with increased postoperative complications, prolonged length of hospitalization, and increased health care costs.<sup>2</sup> In terms of modifiable preoperative risk factors, malnutrition is one of the few that is associated with poor surgical outcomes, including mortality.<sup>3,4</sup> Although referral to a dietitian may be ideal for certain patients, there can be multiple barriers to implementation. Only one out of five patients receives any nutritional intervention in the preoperative and postoperative periods.<sup>5</sup>

Herein lies an opportunity for the family physician to make two recommendations. The first is supplementation with arginine and fish oil, and the second is high-protein supplements taken two to three times daily (minimum of 18 g of protein per serving).<sup>5</sup> Both may be obtained at local pharmacies or ordered online. Supplementation for a minimum of five days for low-risk patients and seven days for those at higher risk has been recommended.<sup>5</sup> A patient at higher risk would have an albumin level of less than 3.0 g per dL (30 g per L) or would meet any of the following criteria: body mass index of less than 20 kg per m<sup>2</sup> if older than 65 years, unplanned weight loss of more than 10% of total body weight in the past six months, or eating less than 50% of a person's normal diet in the past week. In addition, one could communicate that total protein content is more important than total caloric intake.<sup>5</sup>

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## References

1. Damulevičienė G, Lesauskaitė V, Macijauskienė J. Nutritional status of elderly surgical patients. *Medicina (Kaunas)*. 2008;44(8):609-618.

- Gregg JR, Cookson MS, Phillips S, et al. Effect of preoperative nutritional deficiency on mortality after radical cystectomy for bladder cancer. *J Urol*. 2011;185(1):90-96.
- Maliertzis G, Currie AC, Athanasiou T, et al. Influence of body composition profile on outcomes following colorectal cancer surgery. *Br J Surg*. 2016;103(5):572-580.
- Vaid S, Bell T, Grim R, Ahuja V. Predicting risk of death in general surgery patients on the basis of preoperative variables using American College of Surgeons National Surgical Quality Improvement Program data. *Perm J*. 2012;16(4):10-17.
- Williams JD, Wischmeyer PE. Assessment of perioperative nutrition practices and attitudes—a national survey of colorectal and GI surgical oncology programs. *Am J Surg*. 2017;213(6):1010-1018.

**In Reply:** Thank you for your comments on nutrition in older adults. Given the breadth of material we wanted to cover on the perioperative visit, we focused our nutritional assessment and intervention recommendations on areas with the strongest supporting data. The study by Williams and Wischmeyer quoted by Dr. Orlovich in his letter looked primarily at colorectal and gastrointestinal surgical oncology programs; although they comprise a large number of surgeries that older adults undergo, they are not inclusive of all the types of surgeries in older adults.

Malnutrition increases length of hospital stay and related costs and is associated with an increased risk of adverse postoperative events. Assessment should include history of unintentional weight loss and documentation of baseline weight, height, and albumin level. If available, and if time permits, patients identified to have poor nutrition may benefit from referral to a dietitian for a comprehensive plan to optimize nutritional status. Nutrition recommendations may include modifications to diet, food consistency changes, and nutritional supplements. Compared with no intervention, dietary advice and/or nutritional supplements improve body weight, muscle bulk, and strength, although there is inconclusive evidence of improved survival. Patients with dentures should be reminded to bring them to the hospital to facilitate appropriate caloric intake postoperatively.<sup>1</sup>

Current studies are too heterogeneous and lack conclusive evidence that preoperative oral *nutritional* support with dietary supplements improves outcomes for patients undergoing surgery.<sup>2</sup>

Other barriers include adding supplements in patients who may already take a number of medications and our limited understanding of how these natural supplements may or may not interact with a patient's current medications, especially given concerns around the lack of U.S.

Food and Drug Administration monitoring for nutritional supplements. Cost is also a major factor for older adults.

We agree that a focus on nutritional support and supplementation is an important area of further research, although it remains unclear whether it improves surgical outcomes or mortality for older adults when started before surgery.

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## References

- Chun A. Medical and preoperative evaluation of the older adult. *Otolaryngol Clin North Am*. 2018;51(4):835-846.
- Bruns ER, Argillander TE, Van Den Heuvel B, et al. Oral nutrition as a form of pre-operative enhancement in patients undergoing surgery for colorectal cancer: a systematic review. *Surg Infect (Larchmt)*. 2018;19(1):1-10.

## Corrections

**Strength of evidence.** The article, “The Pregnant Patient: Managing Common Acute Medical Problems” (November 1, 2018, p. 595), contained an error in the third sentence of the second paragraph of the “Common Symptoms During Pregnancy” section in the second column on page 597. This sentence stated that there was modest evidence that P6 acupressure can be a first-line therapy for nausea in patients who are pregnant, rather than stating the level of evidence was weak and that P6 acupressure can be a treatment option in this population. This sentence should have read, “There is weak evidence that P6 acupressure can also be a treatment option.” The online version of the article has been corrected.

**Incorrect disease risk.** The article, “The Pregnant Patient: Managing Common Acute Medical Problems” (November 1, 2018, p. 595), contained an error in the third sentence of the second paragraph of the “Dysuria” section in the first column on page 601 regarding the use of trimethoprim/sulfamethoxazole in pregnant patients and the associated risks to the newborn. This sentence should have read, “Trimethoprim/sulfamethoxazole is generally not recommended for use in pregnancy because of risks of neural tube defects in early pregnancy, as well as kernicterus in the newborn and permanent neonatal neurologic damage.” The online version of the article has been corrected. ■