American Board of Family Medicine

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April 9, 2024

Dear Wayne Forde, MD, FAAFP:

Thank you for your letter dated February 6, 2024. We appreciate you taking the time to reach out to the American Board of Family Medicine (ABFM). ABFM is in agreement with the Ohio AFP chapter, and we fully support the AAFP policy on race-based medicine.

We are very concerned about the history and impacts of race-based medicine. We have worked extremely diligently and with great focus on this issue over the past three years to remove any race-based clinical questions in our self-assessment and summative assessment certification activities.

Examples of this are removing notation of race from many questions that had a preamble of the following example: “A x-year-old Black male sees you for X.”

We also have reviewed and rewritten all answer critiques that cited race-based research or algorithms and/or had prevalence rates tied to race without acknowledging the impacts of racism on creating those health differences. In several instances, we added language on how prior raced-based recommendations were not supported by evidence.

I am happy to report that your concern regarding question 43 in the older version of the Diabetes Knowledge Self-Assessment (KSA) has been totally rewritten and will be updated shortly. At that time and for this question, the American Diabetes Association (ADA) cited studies of research done regarding BMI and diabetes prevalence which demonstrated a lower BMI was associated with an increased risk of diabetes particularly in persons who identified as South Pacific Islanders or Asian, which led to these enhanced screening recommendations based on BMI. The ADA annually updates their screening recommendations and the care and management of diabetes. At the time of the publication of the KSA, the current screening recommendation from the ADA was used.

We also agree that it is vitally important to consider the impacts of social determinants of health, social deprivation, and the deleterious impacts of structural racism can lead to underdiagnosis of early diabetes in many groups of people that share common ancestry or live in disadvantaged neighborhoods. And therefore, recommendations need to reflect enhanced resources and screening for people who may be at increased risk.

We believe in the future, the ADA and other organizations will move away from race-based language and toward more of a descriptive narrative language, because of the inherent flaws in race-based

recommendations. We expect they will come forward with a more nuanced recommendation that considers many different social factors.

Until that time, we are left with how exactly to deal with existing guidelines, articles, and evidence that contain race-based language. While Diplomates will still encounter race-based recommendations and race-based literature, it is our hope that they will be able to read a guideline and apply a critical appraisal framework to it to determine if and how to use it. That framework starts with the basic fundamental truth: there is no genetic or biologic basis for race and moves on to more advanced appraisal of the specific harms of a given piece of literature, which includes identifying how race is used, and what it is a proxy for.

Once again, thank you for reaching out and helping ABFM in our mission to improve the quality of care provided by family physicians.

Sincerely,

Keith Stelter, MD
Medical Director of Certification
American Board of Family Medicine