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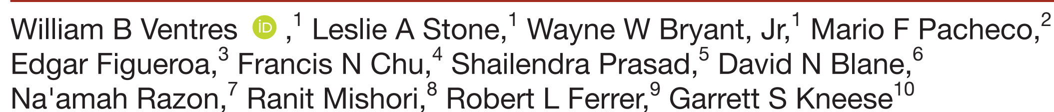
Family Medicine and Community Health

Storylines of family medicine X: standing up for diversity, equity and inclusion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ABSTRACT
Storylines of Family Medicine is a 12-part series of thematically linked mini-essays with accompanying illustrations that explore the many dimensions of family medicine as interpreted by individual family physicians and medical educators in the USA and elsewhere around the world. In 'X: standing up for diversity, equity and inclusion', authors address the following themes: 'The power of diversity—why inclusivity is essential to equity in healthcare', 'Medical education for whom?', 'Growing a diverse and inclusive workforce', 'Therapeutic judo—an inclusive approach to patient care', 'Global family medicine—seeing the world "upside down"', 'The inverse care law', 'Social determinants of health as a lens for care', 'Why family physicians should care about human rights' and 'Toward health equity—the *opportunome'.* May the essays that follow inspire readers to promote change.

INTRODUCTION
Recent events in the USA and around the world have highlighted just how important it is for medicine to address issues of diversity, equity and inclusion in all their dimensions. It is categorically undeniable that people who live 'on the margins' (as determined by economic hierarchy, racial and ethnic discrimination and both urban and rural geographical isolation, among other adverse life circumstances) have poorer health outcomes than those who are considered in the mainstream of today's society. These inequities will not be solved by a culture of medicine that continues to prioritise highly centralised, intervention-dependent subspecialty care; however, family medicine offers a piece of the solution: a robust model for transformative education and generalist practice that challenges medicine's *status quo* and offers hope for a more just future, at home and around the world.

THE POWER OF DIVERSITY—WHY INCLUSIVITY IS ESSENTIAL TO EQUITY IN HEALTHCARE
Wayne Bryant

Creating inclusivity in healthcare is a goal that we as family physicians—and all healthcare practitioners—must strive to accomplish. Together, we must stand for diversity, equity and inclusion.

Black physicians commonly experience prejudice and stereotyping from patients. I vividly remember a patient who expressed his disappointment on seeing me for the first time. He said, 'Aw man, my physician is Black? Is there anyone else that I can see? I thought you were going to be White or Asian.' His comment was a shock, but I saw it as an opportunity to educate him that a doctor's race or ethnicity does not determine competence or compassion.

Ironically, the patient before me looked like me. He too was a Black man. During our interaction, I could not help but wonder why he did not want someone like him to be his family physician. He apologised at his next appointment, explaining that he did not expect me to look the way I did. His initial reluctance had nothing to do with the quality of care I provided. He simply had never had a Black doctor before.

We know that inequalities in healthcare access lead to disparities in health outcomes.[1] To address this issue, we must promote inclusivity and diversity in healthcare. Inclusivity means everyone should have access to healthcare services that meet their needs regardless of their background. Diversity in healthcare means that healthcare practitioners should reflect the diversity of the greater community. This includes diversity in terms of race, ethnicity, gender, sexual orientation, socioeconomic status, religion and disability status. This can lead to improved health outcomes,

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Figure 1 Working together toward inclusivity. Adapted with permission.[3]

increased patient satisfaction and a more equitable healthcare system (figure 1).[2 3]

Let us not stop there, however. All people should have access to healthcare services that meet their needs, regardless of background, identity or socioeconomic status. Embracing diversity and inclusivity means that all family physicians and other healthcare practitioners must learn to understand and address the unique needs of their patients, especially regarding the issues noted above. We must remember that we should include community stakeholders when making 'top-down' decisions. Engaging community stakeholders in the discussions before implementing interventions in healthcare is crucial for ensuring that the changes will work effectively within the community and foster trust in the communities we serve.

Let us all aspire to be called physicians whose willingness to learn and grow in cultural self-awareness outweighs any preconceived notions we might have.[4] Let us all work towards changing the image of what physicians look like. Let us work towards changing whatever preconceived biases we may have regarding our patients. Finally, let us dismantle the structures of institutional racism that exist in our healthcare system.[5]

Recently, I saw my patient again for a follow-up. He arrived at our clinic hours early to ensure he could see me—and only me! On routine exam, I discovered a mass on his thigh that was three centimetres. I advised him to go to the emergency department for urgent evaluation and management. Unfortunately, his ride could not wait for him, and he left before receiving further treatment. I saw him two weeks later, and the mass had grown to five centimetres. At this point, I suspected a cancerous tumour and immediately referred him to surgical oncology. Thankfully, all went well.

My patient no longer saw me as a 'Black physician', one he was initially reticent to see. Instead, I became his physician, the one to whom he entrusted his care.

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MEDICAL EDUCATION FOR WHOM?

Mario Pacheco

Becoming a doctor is a privilege no medical student or resident should take lightly. Let us all contribute to making sure that medical education puts that privilege to use for those of greatest need.

The answer to the question 'Medical education for whom?' can take many forms. Our own individual experiences and personal observations commonly influence our thoughts about how best to approach this question and address healthcare workforce needs. Consider my story.

I am the 10th of 12 children born to parents who, despite significant socioeconomic challenges, both graduated from high school and raised their family on a small farm in rural New Mexico. The idea of becoming a doctor never crossed my mind until I was injured in a horse-riding accident my senior year of high school. I was cared for at the nearest hospital by a family physician who referred me to a neurosurgeon in Albuquerque.

My first inclination was to become a neurosurgeon. Then, after being accepted into medical school, I participated in an experimental, student-focused, small-group, problem-based curriculum at the University of New Mexico. During my first two years of medical school, I learnt the basic sciences in facilitated small group tutorials rather than in a large lecture hall. The creators of this curriculum, and many of the faculty facilitators, were family physicians.

Suddenly, I had a group of role models who were family physicians. They helped me understand the critical role the rural family physician had played when he accurately diagnosed my brain injury—a fourth cranial nerve palsy—and made the appropriate referral to the tertiary care hospital where I recovered from my horse-riding injury. Influenced by this experience, I became a family physician. I have since become the founding director of a rural family medicine residency programme whose continuity clinic is based at a federally qualified health centre. I also serve as the director of the Health Extension Rural Officers programme, and I continue to practise in rural northern New Mexico.

Prior to starting my medical education, my professional considerations were largely the result of luck and, very simply, accident. On entering an innovative medical programme, however, I was fortunate to receive the support I needed to succeed as a community-engaged family physician. Certainly, many medical students have stories like mine, yet even today, many students

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Figure 2 Educating ourselves for the public's health.

seem predestined to enter medical specialties based on concerns of privilege rather than community needs.

Developing a medical workforce appropriate for community needs requires that we must:

- Establish pipeline programmes that recruit high-performing high school students from historically under-represented populations into medicine.
- Decentralise the medical school admissions process, incorporating community input on who has the potential to be a good doctor.
- Embolden medical students to work with health extension agents embedded in rural and urban communities of need.
- Prepare students beyond the limits of their hospital-centric, tertiary care training to prioritise the knowledge, skills and attitudes necessary to serve communities whose health outcomes are poor due in part to geographic distance, lack of access to robust healthcare services and economic and social isolation.

To answer the question 'Medical education for whom?' students, residents and educators alike must be broad in their thinking and inclusive in their actions—it is the only way to appropriately respond to the needs of all people (figure 2).

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GROWING A DIVERSE AND INCLUSIVE WORKFORCE

Edgar Figueroa

The practice of family medicine is a team effort, and the family medicine team can achieve more when it includes individuals with different experiences and perspectives while sharing a common vision to improve a community's health.

We as family physicians harness our unique experiences and training to improve the health of patients and communities. We provide a broad range of care in diverse geographical and clinical settings to populations that are increasingly diverse in myriad ways, including race, ethnicity, languages spoken, disabilities, socioeconomic status and gender expression (figure 3).[6]

Like all areas of medicine, however, the family medicine workforce does not currently reflect the same level of diversity as our patients.[7] This puts patients at risk of suboptimal care or foregoing medical care altogether.[8] Clinicians from diverse backgrounds are also experiencing differential workloads and burnout, which can drive them out of this incredibly fulfilling career.[9 10] The combination of patient non-engagement and staff turnover can have deleterious effects on the financial status of a practice or organisation, jeopardising its ability to remain available to those that need it most.

The COVID-19 global pandemic and social justice movements, such as Black Lives Matter, Stop Anti-Asian Hate, and Me Too, have resulted in increasing public calls, for institutions, to re-examine their policies and procedures to promote inclusion and equity. There are also calls for these organisations to be held accountable by the communities they serve.

Academic family medicine and its related professional organisations have responded in part by forming committees and task forces addressing issues such as diversity, equity, inclusion, antiracism and belonging in all aspects of an organisation's mission. However, there is no 'one size fits all approach' that can be applied to family medicine organisations. The following suggestions are things

Figure 3 Toward workforce diversity and inclusion in family medicine. Adapted with permission.[6]

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all of us can keep in mind in our daily work as we strive to build a more diverse and inclusive workforce:

- Diversity and inclusion are not the responsibility of any one member of an organisation.
- It is important for individuals, particularly those in leadership roles, to identify their own unconscious biases and to take steps to mitigate these in both patient care and in recruitment.[11]
- The process of inclusion is not passive but requires an intentional commitment on the behalf of leadership to actively identify and invite those who are missing from the group to participate in meaningful ways. This requires looking, listening and learning. Those not in leadership can play important roles in being vocal advocates and allies.
- This is not a 'one and done' type of activity and is no different than the continuous quality improvement programmes we operate in our practices and residency programmes. The goal is not simply to check a box and consider the diversity goal satisfied.
- Education and training activities are valuable, but identifying individuals who can serve as mentors and role models, without being unduly burdened, is critical to diversifying the workforce.[10 12]

Family medicine is the generalist specialty with the most diverse geographical reach and patient population, so it is only fitting we lead the way in coming up with the ways to make our workforce more diverse and inclusive—our communities are counting on us.

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THERAPEUTIC JUDO—AN INCLUSIVE APPROACH TO PATIENT CARE

Francis Chu

Therapeutic Judo is a universally applicable process of connecting with patients in need.

Unbridled anger and demands that required satisfaction filled the hospital room, all directed at me. Mrs Fuentes was upset that her husband's previous doctor had not taken care of him well; her husband's condition had no firm diagnosis and he was obviously declining and in pain.

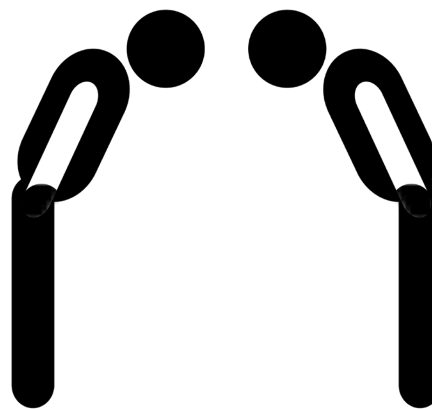

Figure 4 Therapeutic judo: honouring the patient.

Sensing her frustration, anxieties and fear, I apologised and asked Ms Fuentes what she expected from me. I told her I would do my best to address her concerns. As she laid out her requests, I could feel the tension in the room melting away. Although the temperature in the room would still rise occasionally during the next few days in the hospital, as I spent time caring for Mr Fuentes, his wife gradually realised they had an ally working with them to meet their needs.

In family medicine, as in other primary care disciplines, the dose, frequency and route of the doctor as medicine is an art that all physicians empirically prescribe and adjust throughout their relationships with patients.[13] Some patients take this medicine easily and willingly, usually when the relationship is pleasant and enjoyable. When facing a patient who seems challenging—confusing, different or difficult (meaning hard to please, demanding, non-adherent or confrontational)—as family physicians we learn to navigate these challenging waters by not only recognising the signs of frustration, but by getting curious, digging deeper to find common ground and finding the proper manner of applying ourselves to our patients' situations.

Motivated by a desire to improve the relationships that form the foundation of our healing bonds, family physicians practise what I call *therapeutic judo*—a way to leverage our patients' own ideas and goals to help guide them towards mutually acceptable outcomes (figure 4).

Therapeutic judo begins with a symbolic bow of recognition: an acknowledgement of patients' inherent worth and dignity. A few minutes of deep listening follow.[14] After this, physicians can employ any one of other therapeutic actions as the clinical interaction unfolds. Expressing a kind word. Offering a tissue for tears. Lending a touch on the shoulder. Inviting an embrace of encouragement. Speaking a phrase in the patient's mother tongue or making a culturally sensitive gesture. Acknowledging pain and suffering, or even just sitting together in silence. Standing shoulder to shoulder with the patient instead of confronting them face-to-face.

If done with selfish or impure motives, these actions can be seen as manipulative or deceptive. Like any other prescription, it is possible to give the wrong dose or route,

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cause unintended side effects or even harm. However, when coupled with empathy, kindness and understanding that caring physicians bring to the relationship, they can be a restorative salve to heal the souls of both patients and physicians. This deepens the trust on which the doctor–patient relationship is built.[15]

Therapeutic judo can be useful with all patients, young and old, rich and poor, well-educated and literacy challenged, clinically sophisticated or medically naïve, native-born or recent immigrant, of whatever colour or creed or any other distinctions that might seek to separate us from our patients. It can help us cross the seemingly unbridgeable chasm that comes between our shared humanity.

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GLOBAL FAMILY MEDICINE—SEEING THE WORLD 'UPSIDE DOWN'

Bill Ventres and Shailey Prasad

Practising global family medicine means more than working internationally. It means seeing the world from new perspectives, applying skills in solidarity with people in need and learning from others.

Global family medicine embraces many themes, including educating medical professionals at home and abroad about the importance of family medicine as a foundational element of primary care, developing family medicine training programmes in resource-limited settings to help ensure the provision of equitable medical care, and striving to ensure that family medicine is an essential part of health systems around the globe.[16,17]

From a philosophical perspective, the concept of global family medicine means seeing the health of the world's people in all its complexity, from a point of view that includes, but is not limited by, the confines of the biomedical model.[18] This concept of global family medicine prioritises the needs of those people around the world who disproportionately suffer under the burdens of economic poverty and social marginalisation, both of which are caused by political and economic structures that preferentially benefit the rich and powerful.

For physicians from the USA and other economically wealthy countries, global family medicine means looking beyond their training in increasingly fragmented professional cultures that neglect the basic tenets of primary care, community health, social accountability and the provision of universal healthcare. It means understanding how basic principles like access, equity and appropriateness are essential to improve health outcomes in medically underserved settings.

Figure 5 Can you see the world 'upside down'?

Global family medicine means doing the conceptual work of turning the world 'upside down' from its conventional orientation, just as skilled physicians do when practicing patient-centred and people-centred clinical care, wherever they may be (figure 5). The goal in each circumstance is to recognise differences in how people approach the structure and delivery of medical care, to understand that many non-biological factors influence the presentation and amelioration of disease and illness and to practise where need is greatest (eg, in locations most affected by adverse social determinants of health). Global family medicine builds on the tenets of primary care by encouraging its practitioners to embrace five attitudes[19] :

- **Awareness**—Open one's eyes, ears and mind to the historical, social, cultural, political and economic contexts of the communities in which people live, work and play.
- **Curiosity**—Adopt a questioning approach—an anthropological gaze[20]—to patient and community concerns. Exercise one's senses, so often heightened in unfamiliar settings, to engage in honest, realistic and inclusive assessments of how upstream causes affect disease and illness.
- **Humility**—Engage with others aware of the hold that unconscious attitudes (including desires for power, yearnings for control, hopes for receiving thanks and the conceit that what we have, others in the world must want) can play in interactions across cultural and geographic boundaries.
- **Meaning**—Work *with* patients, families and communities, not just *for* them; find worth in solidarity—in sharing—rather than simply in doing. Solidarity signifies recognising, with others, the structural forces that contribute to poor health outcomes; it also signifies recognising, with others, the structural barriers that negatively affect abilities to ameliorate those forces.
- **Intention**—Learn through one's work of practicing and growing global family medicine. True learning

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implies welcoming a definitive change in some aspect of one's own life.

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THE INVERSE CARE LAW

David Blane

The greater the healthcare needs of any population, the less likely good medical care is available to that population. This concept, called the inverse care law, is most prevalent where market forces influence the provision of medical services.

The *Inverse Care Law*, a term coined in 1971, is—at its simplest—the observation that disadvantaged populations need more healthcare than advantaged populations but receive less.[21] At a global level, in countries where healthcare can only be accessed by those who can afford to pay, this observation is most pronounced and is often the difference between life and death.

Yet even in countries with universal healthcare systems and no user fees to access care, the inverse care law persists. Medical services are not the main driver of mortality and morbidity, but the distribution of healthcare resources is a fundamental—and often overlooked—determinant of health and, therefore, of health inequalities. If good-quality healthcare is not accessible where it is needed most, inequalities in health will inevitably widen.

In the context of family medicine and general practice, however, the distribution of resources rarely matches needs. Research has shown that areas of high deprivation tend to have higher healthcare needs yet on average have fewer general practitioners (GPs) with higher workloads, more patients and higher stress.[22] The inverse care law in generalist practice manifests as insufficient time to adequately respond to the complexity of health and social problems in deprived areas. It is not the difference between 'good' medical care and 'bad' medical care in different areas; instead, it is about what practices in the most disadvantaged areas can do versus what they could do if adequately resourced.

Of course, the inverse care law is not just about the funding and distribution of the family medicine workforce in more socioeconomically deprived areas, as availability of a service is only one piece of the healthcare access puzzle.[23 24] Patients who are socioeconomically disadvantaged or marginalised in other ways often have lower expectations of shared decision-making, lower health literacy and are less able to navigate what are often complex health and social care systems.[25]

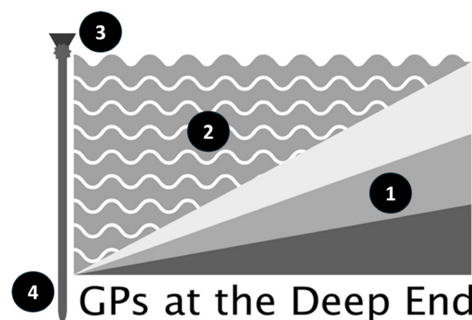

Figure 6 General practitioners at the Deep End. (1) The inverse care law illustrated—steep gradients of health needs across the social spectrum, alongside flat distributions of funding and accessibility; (2) a swimming pool—Deep End practitioners often struggle to keep their heads above water while addressing the complexity of their patients' needs; (3) a thistle—a nod to the Scottish origin of the Deep End project; (4) a spurtle (a traditional Scottish utensil used to stir porridge)—Deep End practitioners stir the pot and agitate for change. Adapted with permission.[27] GPs, general practitioners.

In response to the Inverse Care Law, the Scottish Deep End Project was established in 2009 as a collaboration between academics and GPs working in the most socioeconomically disadvantaged communities in Scotland (figure 6).[26 27] This has resulted in a growing sense of identity, solidarity and common purpose—to improve the volume, quality and consistency of primary care where it is needed most. Over the last decade, initiatives, which began as pilot projects in a handful of Deep End practices, have been rolled out nationally and emulated internationally: there are now more than 15 deep end networks around the world.

The value of multidisciplinary teams, which include community health workers, mental health workers and financial advisers, is clear. The speed, familiarity and effectiveness of referral to these services are best when they are embedded in generalist practices, building relationships of trust over time. These examples of a community-oriented approach to primary care demonstrate that the Inverse Care law is not a given that must be endured but a challenge that can be overcome.

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SOCIAL DETERMINANTS OF HEALTH AS A LENS FOR CARE

Na'amah Razon

Caring for patients and communities requires that family physicians broaden their lens of care and attend to the social context of the world.

The term social determinants of health (SDoH) refers to the broader world in which both patients and physicians reside. The World Health Organization defines these SDoH as 'the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life.'[28]

Increasingly, SDoH is captured by concrete domains that inform individual and community well-being: safe transportation and housing, access to healthy food, language skills, educational and employment opportunities and exposure to violence. Those who work in clinical settings can use screening tools to characterise how social domains affect patients and ascertain ways to ameliorate risks to health.

Research has demonstrated that social determinants likely account for up to 60% or of individuals' health and risk of illness (figure 7).[29 30] As a result, the healthcare sector increasingly supports ways to address these upstream causes of health and disease. Such efforts include integrating community health workers, non-emergency medical transportation services, medical-legal partnerships and food pantries into practice patterns.

However, social determinants extend well beyond these distinct domains. Using an SDoH lens to care for patients helps family physicians and other practitioners consider the complexity that their biomedical training often fails to examine. When done sensibly and compassionately, attending to SDoH can help family physicians become aware of who their patients really are, what matters most to them, and what it is they need from the medical profession and broader society.

For example, approaching patients with an SDoH lens means seeing an elevated haemoglobin A1C not only as a marker of diabetes but also as a call to acknowledge the foods that individuals can access, the way they store their insulin at home, their ability to pay for medications and the distance they live from grocery stores that carry healthful foods.

Attending to SDoH means not only using stethoscopes to listen to people's hearts but also opening our own hearts as family physicians to hear the stories people share with us. Pieces of these stories may not fit clearly within the history of present illness; however, these stories do inform how patients experience their symptoms and hear our recommendations. Deeply listening to patients can help educate us as to how we might best collaborate with patients when providing care.

Ultimately, using an SDoH lens means engaging with individual patients to understand the worlds in which they grew up in and now live in. It means hearing stories not only of racism, marginalisation and loss but also of opportunity, optimism and hope. It means gathering the people who matter to our patients and working together to heal old wounds while fostering new resiliencies.

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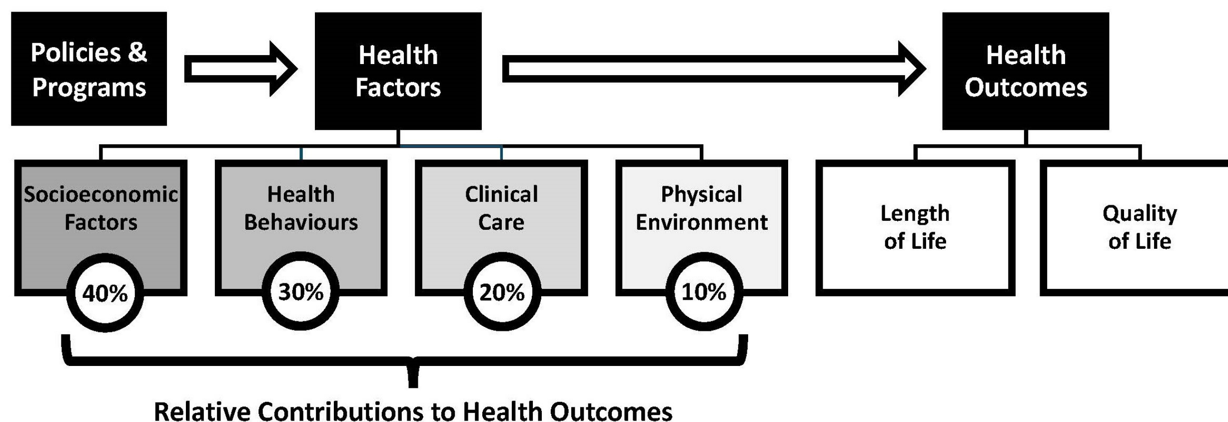

Figure 7 SDoH and health outcomes. Adapted with permission.[30] SDoH, social determinants of health.

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WHY FAMILY PHYSICIANS SHOULD CARE ABOUT HUMAN RIGHTS

Ranit Mishori

Human rights are essential for protecting and promoting health.

Throughout training and practice, family physicians and other health professionals will encounter individuals whose health and well-being have been directly impacted by violations of civil and human rights. Such encounters involve the clinical care of survivors of torture, victims of human trafficking, incarcerated people and refugees fleeing persecution and conflict in their home countries, among others.[31 32]

The concept of human rights emerged as an aspirational set of principles, which were outlined in the Universal Declaration of Human Rights (UDHR) and ratified by the United Nations in 1948.[31] In matters of health, the most cited article of the UDHR is Article 25: 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.'[31]

The UDHR principles have been further developed and incorporated into international treaties and conventions as well as into national laws in many countries; they form the basis of human rights-informed laws and policies.

Family physicians, with their specialised skills, ethical duties and professional voices, are well positioned not only to care for survivors but also advocate for the prevention of human rights violations and promote health systems that are rights-respecting, antidiscriminatory and antiracist.[33] In fact, human rights and family medicine share several guiding principles:

- Seek to promote the health and well-being of individuals and communities.
- Believe there is an intrinsic value in alleviating human suffering.
- Share an underlying belief in the inherent dignity and worth of individuals.
- Include dimensions both practical and moral.

Family physicians can incorporate human rights into their work by teaching about the health consequences of human rights abuses; they can also apply clinical best practices in response to such abuses. Family physicians can enlist the credibility and power of our profession to advocate for equality, dignity and other human rights. They can also conduct research about rights-respecting or rights-violating trends.[34]

Family physicians can apply a Human Rights Based Approach to Health (HRBAH).[35] This approach is based on a core set of beliefs in which everyone lives with dignity, freedom, justice, equality and peace. A HRBAH seeks to achieve a healthcare system that incorporates the following key principles: availability, accessibility, acceptability, quality of facilities and services (known as the AAAQ framework),[36] as well as participation, equality, non-discrimination and accountability. Importantly, the HRBAH goes beyond how to engage with individuals and seeks to integrate human rights norms and principles into the design, implementation, monitoring and evaluation of health-related policies and programmes. Champions of a HRBAH also work to empower rights holders to effectively claim their health rights.

Figure 8 Humanity is our patient. Adapted with permission.[38]

The AMA Declaration of Professional Responsibility states, on behalf of all physicians, that 'humanity is our patient' and asks physicians to 'use their skills' beyond the bounds of the traditional patient–physician relationship in 'responding to exceptional global conditions' and need for care.[37] By adopting a HRBAH, family physicians and others—individually and collectively—can do just that (figure 8).[38]

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TOWARD HEALTH EQUITY—THE *OPPORTUNOME*

Bob Ferrer and Garrett Kneese

A variety of widely shared political, economic and environmental conditions—conditions collectively referred to as social determinants of health—shape the health of populations. Think of these as the social context in which people live.

We live in the age of *omics*, shorthand for the study of complex cellular and molecular systems (eg, genome, transcriptome, proteome, metabolome, connectome). We hope study of these systems will help us develop cures for the maladies that shorten so many lives. Yet, if

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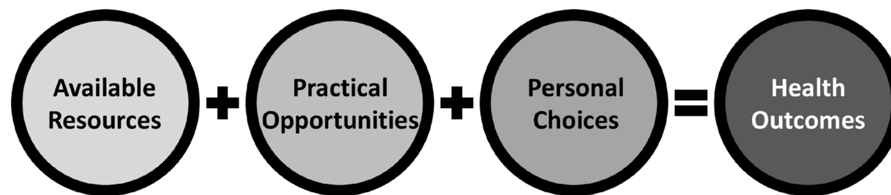

Figure 9 Health in social context = the *opportunome.*

allowed just one question to estimate the lifespan for any randomly selected human on earth, one could make a strong case to bypass biology and head straight for geography: 'Where do they live?'

Nation, town or neighbourhood—place is the most informative starting point when considering lifespan. This is because place includes the social, economic and political policies that influence one's health and lifespan. Epidemiologists have collected substantial evidence that supports SDoH as the primary forces driving inequalities in longevity and well-being.[39] To be clear, pathologies have biological mechanisms that contribute to poor health outcomes; however, the root causes of many pathologies are social.

Like our primate brethren, we are sensitive to our place in the social hierarchy. Our perceived status shapes our physiology in predictable ways, rewiring brains and reshaping bodies. As we age, our bodies become ledgers of the conditions we faced throughout life, and these ledgers are unforgiving. In the USA, people living in lower income percentiles have shorter life expectancies than those living in higher percentiles. Even minor differences in these percentiles affect lifespans.

Because SDoH establish the conditions of everyday life, it is essential to develop environments in which everyone can thrive. How to get there, however, is the difficult question. What duty does a society bear to ensure that opportunities for health are widely shared?

A Capability Approach, a practical ethical and action framework from Human Development Economics, is a useful perspective from which to frame an answer.[40 41] Capabilities are practical opportunities to achieve the goals one values (eg, to be well-educated, safe and physically vigorous). Practical means opportunities are available and realistic across the spectrum of needs and abilities.

The Capability Approach informs a new 'omic' advancing health equity: the *opportunome*. The *opportunome* consists of a community's set of feasible opportunities for a healthy, dignified life. In parallel to the molecular omics, the *opportunome* is measurable for both individuals and populations. We already have many of the tools to do so.

Focusing on the *opportunome* does not absolve individuals of responsibility for their own health. Nevertheless, we must judge actions in light of available opportunities, not in spite of them. Failing to account for SDoH means remaining indifferent to the reality that the de facto social hierarchy determines the value of people's lives. Together, SDoH and the *opportunome* provide us with a lens and a vocabulary to promote health equity for all (figure 9).

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