EDITOR’S NOTE

A n essay in family physician Therese Zink’s 2012 collection of stories, *Confessions of a Sin Eater*, capsulizes health equity. In “Caring for Lucy,” Zink tells the tale of a 9-year-old girl who presented to the rural urgent care clinic where Zink was working complaining that “sometimes I can’t see.” Zink sees a pre-adolescent with greasy hair and poor dentition accompanied by a concerned-but-reserved mother. Following her standard doctor script, Zink does a thorough physical examination and orders some tests, all of which were normal. The medical encounter could have ended there—flaky pre-teen with uninterpretable symptoms; pat her on the hand and reassure her and her mom that all is well. But Zink delves past the scruffy appearance of the child and the reticence of the mom and uncovers a frightening home environment: an ominous boyfriend, a history of past domestic abuse by a previous husband, trips to domestic shelters—all salted with debilitating poverty making every avenue of escape difficult, if not impossible.

The true etiology of her patient’s symptoms would have remained obscure had Zink not treated the girl as she would any patient, ignoring her offensive appearance and working overtime to root out the source of her problem. Equity in the exam room means treating each patient as if they were your most important patient, regardless of gender, sexual orientation, race, ethnicity or personal appearance.

The practice of medicine harbors lots of opportunities to feel impotent—the untreatable cancer, the irretrievably damaged heart, the recalcitrant alcoholic. We frequently sigh and move on to more approachable, workable problems. Our exam room health equity problem is approachable and solvable. To fix the bigger upstream conundrums, however, we can do what we can and also support those working on the upstream territory.

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Beneath the surface