On TRACK

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Ann Fam Med 2004;2:177-179. DOI: 10.1370/afm.132.

Since the last issue, the Topical Response to the *Annals* Community of Knowledge (TRACK) online discussion has brought together the voices of patients, clinicians, researchers, educators, and policy makers.

MULTIMETHOD RESEARCH FITS PRIMARY CARE

The study by Creswell et al[1] and the accompanying editorial by Borkan[2] resonated with respondents who appreciated having a typology for mixed methods research.[3-5] Two discussants showed how good clinical care, like multimethod research, involves a mixture of quantitative and qualitative data collection and analysis.[6,7] Perhaps this is one reason that mixed methods appear to fit primary care research—their complexity and integration of different ways of knowing is a reflection of the phenomena that are studied.

Elverdam[8] points out the danger of thwarting the potential of qualitative methods to discover meaning from the perspective of the informants when methods are mixed and the qualitative methods are used only as "helpers" for the quantitative methods. Such an approach may diminish discovery of "diversity and individuality as well as shared attitudes and actions." Elverdam challenges that qualitative data be fully analyzed to bring out "exceptions, the breaking of principles," or understanding of context. This challenge matches the early experience of the *Annals* editors, who often encourage authors of qualitative research studies to go further in the analysis to bring out larger meaning, context, and interpretation.

Likewise, Solberg[9] challenges the authors of the Creswell et al study to go further in developing a typology that goes beyond describing categories of mixed methods research, to provide criteria for judging quality. Solberg closes by hypothesizing "a side benefit" – that multimethod research "may generate greater involvement, interest, and ownership" (by the participants) "making it more likely that they will do something with the results." "If a picture is worth 1,000 words, a good story may be worth 1,000 pictures."

In critiquing the application of a multimethod approach by Schillaci et al,[10] Hambidge and Daley[11] identify the ecological fallacy and regression to the mean as potential threats to the interpretation of the study's quantitative data. The study attributed reductions in immunization rates in New Mexico to the introduction of Medicaid Managed Care. Hambidge and Daley raise concurrent funding cuts to public immunization programs and other changes in health care delivery as alternate explanations for the state's fall in state ranking of childhood immunization rates. Both Hambidge and Daley[11] and Bocchini[12] cite the importance of the frontline perspective from clinical practice sites for understanding and improving care.

We look forward to seeing the *Annals* continue as a forum for integrating the different ways of knowing that are possible with multimethod research, and to continued incisive discussion by readers.

"RAISE THE FLAG OF RELATIONSHIPS!"

The study by Boyle and Solberg[13] inspired comments from the medical director of a Medicare peer review organization and an *Annals* editor. This study found no effect of treating smoking status ascertainment as a vital sign on cessation counseling rates. Petrulis[14] found support for more complex, multilevel interventions in this study. Miller[15] found the basis for complex and messy systems change "that might help to undermine our culture's obsession with rational simplicity." I invite readers to react to this call for revolution to "raise the flag of values, agency, and communion; raise the flag for relationships!"[15]

"TOWARD MORE CREATIVE AND CONSISTENT DOCTORS"

Several readers found meaning and a call to action in the study of diabetic smokers by Solberg et al.[16] From different vantage points, these commentators[17-19] call for greater prioritization of the complex needs of diabetics for care that goes well beyond glycemic control to consider comorbidity, smoking, depression, risk

factors, and behavior change. They call for systems support that allows the clinician to prioritize and individualize, while involving staff, and especially patients, in matching the treatment to the patient's needs and readiness to change.

"IT HAS CHANGED HOW I APPROACH THE MANAGEMENT OF PATIENTS"

In a timely study for the flu season, the cost-benefit analysis by Hueston and Benich[20] changed one physician's practice,[21] and created a call for information or tools to judge the probability of influenza.[21,22] Do any readers know of such tools or information? How can Dressler's call for "accurate and up-to-date information on the incidence of influenza in my local area"[21] be realized? As we now know from the Hueston and Benich analysis, timely information on local influenza rates is important for effective treatment decision making.

DON'T GIVE UP ON RELIGION YET

Daaleman et al[23] found an association between health status and spirituality but not religiosity among geriatric outpatients. While supporting the study's key finding on the importance of spirituality, King[24] warns that because of design and measurement limitations of the study, "it may be too soon to discount the importance of religious attendance and religious coping in the geriatric population."

"LONG-TERM SURVIVORS OF CHILDHOOD CANCERS NEED HELP"[25]

The multisite study by Oeffinger and colleagues[26] generated the most commentary of any article published so far in the *Annals*. From the United States and abroad, from the disciplines of medicine, psychology, social work, epidemiology, and nursing, and most poignantly from the lived experience of childhood cancer survivors, a picture of often unmet need emerges. This need is balanced by opportunities to improve the health care of cancer survivors by activated and self-advocating patients, and by increasing communication between and among specialists, generalists, and patients. Opportunities are identified for tailored follow-up and additional research. Fran Culp,[27] one of many TRACK discussants who participate in a Long Term Survivor online discussion group, outlines a 5-point program for improving the lives of childhood cancer survivors. Her plan includes raising awareness among medical professionals and patients alike, modifying disability program rules, conducting new research, and supporting greater health insurance accessibility. The cogent arguments and compelling stories of this community are a collective call to action and worthwhile reading for anyone who may be touched by cancer. That includes us all.

THE FUTURE OF HEALTH CARE

The essay by Rastegar[28] stimulated thoughtful and optimistic reflections on the future of health care. These analyses bring together historical, systems, and spiritual dimensions.[29-32] We suspect that these reflections presage a forthcoming active discussion which will be stimulated by the report of the Future of Family Medicine Task Force[33,34] in the supplement to this issue of the *Annals*.

The editors thank all discussants for their very thoughtful commentaries. We encourage others to join the discussion of these or other articles published in the *Annals* at http://www.annfammed.org.

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CORRECTIONS

In the article by Hueston and Benich in the January-February 2004 issue of the *Annals* (Hueston WJ, Benich JJ III. A cost-benefit analysis of testing for influenza A in high-risk adults. *Ann Fam Med.* 2004;2:33-40), an error occurred on p. 35, in Table 1, Baseline Probability and Cost Assumptions for Influenza: Testing-Treatment Model. The sensitivity test range for probability assumptions, test specificity, %, is displayed as 80-00. The correct sensitivity test range should be 80-100.

In the article by Daaleman et al in the January-February 2004 issue of the *Annals* (Daaleman TP, Perera S, Studenski SA. Religion, spirituality, and health status in geriatric outpatients. *Ann Fam Med.* 2004;2:49-53) the link to the supplemental appendix is not correct. The correct URL is http://www.annfammed.org/cgi/content/full/2/1/49/DC1.

In the article by Phillips et al in the January-February 2004 issue of the *Annals* (Phillips RL Jr, Fryer GE, Chen FM, et al. The Balanced Budget Act of 1997 and the financial health of teaching hospitals. *Ann Fam Med.* 2004;2:71-78), the link to the supplemental appendix is not correct. The correct URL is http://www.annfammed.org/cgi/content/ful/2/1/71/DC1.

The publisher regrets the errors.

In the Association of Departments of Family Medicine Family Medicine Updates (*Ann Fam Med.* 2004;2:91-92), inadvertently omitted from the list of Family Medicine Departments was Brown University, and its chair, Jeffrey Borkan, MD, PhD. The author regrets the error.