

The First 20 Days

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This issue features the first installment of On TRACK – a synthesis of the Annals' online discussion. During the first 20 days, readers took part in a remarkably thoughtful and stimulating conversation, which is summarized below.

The online conversation is called TRACK (Topical Response to the Annals Community of Knowledge). TRACK offers the opportunity to comment on published articles. We welcome comments from authors, clinicians, patients, families, policy makers, researchers and others. We also offer an Open Forum for brief presentation of preliminary research findings, research questions, methodology notes and other new ideas. On TRACK synthesizes these discussions to integrate diverse perspectives and different ways of knowing.

During the first 20 days of TRACK, 26 comments were posted. With the exception of two requests for medical advice, we posted all submissions. Each original research and methodology article and both editorials stimulated discussion.

In response to the cluster of papers on comorbidity, discussants report that the care of multiple illnesses is an underrecognized aspect of the provision of quality medical care, and is an essential and undersupported feature of good primary care. In discussing the study by Starfield et al,¹ Lawson² calls for a "move from 'case' management to 'care' management." Chirayath³ adds a sociological perspective, noting that depression is an important and often underrecognized comorbidity with critical implications for the provision and integration of health care. She challenges Bayliss et al⁴ to acknowledge more fully that "socioeconomic status is one of the predominant, if not leading, barriers to self-care among this population." This reflects the major point of the article by Rosen,⁵ which calls for risk adjustment measures that incorporate assessment of social environment, health behaviors, and psychosocial factors. In discussing the Rosen article, Katerndahl⁶ goes further, noting that "The ultimate problem with current risk adjustment methods is their failure to reflect the complexity of primary care," and that these limitations "may explain the failure of RBRVS."

Grumbach's editorial⁷ stimulated discussants to consider the patient-centered heart of primary care. Trotter⁸ notes that "the unique distinctive of family practice is its

ability to integrate the care of a whole person, not only in 'coordination of care,' but in every sense of evaluation and management of a person's health and illness." The editors (and discussants Vallabh and Sparks⁹) believe this emphasis on "integration" as opposed to "coordination" should be at the heart of efforts to develop the true value of primary care. Bratton¹⁰ calls for payment and practice reform to allow time to care for patients and complex problems. Guthrie,¹¹ in a compelling case study of her own father, notes the need to "encourage the generalists to take the time and effort to think about the 'big picture,' and to share it with their patients. Most of us want to do this, but the exigencies of reimbursement don't encourage us to do it as well." Teichman¹² calls for educational reform to develop primary care clinicians who can provide the needed "continuous, integrated, community-based care."

The article by Leeman and Leeman¹³ stimulated considerable discussion by those with experience in lowering cesarean delivery rates, including family physicians (Klein,¹⁴ Blenning¹⁵), a nurse-educator (Goetter¹⁶), a medical writer (Goer¹⁷), and the obstetrician-gynecologist, former Chief Clinical Consultant for the Indian Health Service (Waxman¹⁸). They attributed the lower cesarean rates to "expectant management, patience, and labor support," "the philosophy and practices of the (nurse midwife and family physician) care providers," lower use of epidural anesthesia, cultural expectations of the Zuni community, and the organization of care in closely collaborating "low-risk maternity centers participating in a regional network with larger hospitals that have obstetrical specialty and surgical capability." "Allowing more spontaneous labors dramatically reduced the known 'cascade' that follows from anxiety driven inductions."

The Dickerson clinical trial of routine medication vs sliding-scale insulin for care of hospitalized diabetics¹⁹ caused Spann²⁰ to "think twice before writing for sliding scale insulin in a hospitalized type 2 diabetic patient." The study reminded him that, despite the current focus on evidence-based medicine, "we continue to follow therapeutic traditions in our daily practices that have never been submitted to rigorous scientific evaluation." Papeck²¹ notes that his "hospital P&T committee has been looking for an article similar to that researched by

Dickerson et. al," but questions whether different insulin regimes might yield different results.

Regarding Volk's clinical trial of patient education for prostate cancer screening,²² Hashim²³ feels that because of competing demands, "we are at the limits of informed patient decision-making in preventive medicine." Volk's study was designed to address just this concern by priming the discussion with videotaped education that can occur outside the limited visit time.

Surprisingly, the compelling essay by a family physician and his patient, a dancer who was transformed into a painter by stage 4 lung cancer,²⁴ did not stimulate early discussion. We encourage clinicians who care for patients with cancer and cancer survivors themselves to share their experiences and reflections on this piece, and to view the author's paintings online.

Two Family Medicine Updates from *Annals'* sponsoring organizations also stimulated discussion. These updates are not subject to the rigorous peer-review process of *Annals'* scientific articles and essays, but we are delighted that they are stimulating commentary. The article from American Board of Family Practice on maintenance of certification (MOC)²⁵ generated several concerns about the burden of this new procedure, and one validation of MOC as an opportunity to model sustaining quality practice. Respondents commended the American Academy of Family Physicians on their feature on patient safety²⁶. Shreck²⁷ calls for a "just culture" approach to reporting and a "human factors/systems" approach to reducing errors, while Sloper,²⁸ a general practitioner from Jamaica, notes that "General practices in the developing world have probably not embarked far on the road to patient management I.T. (information technology) systems."

Our introductory editorial²⁹ elicited a number of enthusiastic reflections on the *Annals'* potential for meeting the need for a transdisciplinary forum for primary care research. Overall, readers' response to the first issue shows the potential for TRACK to serve as an intellectual commons of primary care by uniting the science of rigorous peer-reviewed research with personal experience. This powerful combination opens the possibility for translating practice and experience into research, as well as for translating research into practice and experience. Participants' insights already have stimulated the mind, enlarged the spirits, and challenged the status quo.

We encourage readers to participate. Go to www.annfam.org and click on "discuss an article" on the home page, or click on "comment on this article" in any article. Consider emailing articles to others and encouraging them to comment online. We welcome the views of patients, clinicians, other professionals, policy makers and other citizens of the world community. Thank you for the privilege of conveying your ideas.

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