EDITORIAL

In This Issue: Powerful Ideas for Action

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Conflict of Interest: Kurt Stange has been a member of the National Commission of Prevention Priorities since it began.

This abundant issue of *Annals of Family Medicine* showcases a plethora of powerful and actionable ideas for improving health, health care, and society.

NURTURING SPACE FOR CIVIL DISCOURSE

A Perspectives editorial by Romano and Grumbach provides a balanced and powerful reflection on recent events in the United States that echo worldwide happenings.[1] They ask us to consider what it means to be a healthy society, and they issue 4 calls to action for family physicians and all who recognize our essential interrelatedness.

I would add a fifth call to action.

Novelist, essayist, and poet Wendell Berry notes that health is (participation in) community.[2] In a time when what passes for public discourse are soundbites designed to elicit an immediate visceral reaction that forces us into one of 2 apparently warring camps, family physicians are uniquely positioned to nurture community. By seeing both the person and the community, by valuing both our differences and our underlying commonality, family physicians can foster healing by creating space for resistance without divisiveness, for finding common ground without giving up core principles, and for growing community, one relationship at a time.

PRIORITIZING: AN UNDERAPPRECIATED ASPECT OF PRIMARY CARE

Prioritizing is an essential feature of robust primary care.[3] Scanning and focusing on the most important items[4] among the 3[5] or 5[6] or 25[7] interrelated medical, social, and environmental problems that people bring to primary care provides tremendous value to individuals, and makes more narrowly focused health care more effective when referral is needed.[8] Prioritizing within the whole-person, relationship-centered primary care approach takes what otherwise might be crude rationing if done at the level of explicit or implicit policy,[9] and turns it into care that focuses on what is most important for the particulars of the individual,[10] while taking into account the trade-offs for the family and community.[11] Prioritizing care based on knowing the person, family, and community protects people from over-treatment[12] and overcomes what otherwise can be a dangerous[13] and lonely journey through fragmented health care.[14,15]

Therefore, we are delighted that the National Commission on Prevention Priorities has chosen to publish the latest update to their work in *Annals*. The National Commission has developed a scientific method for what heretofore has been the art of medicine and policy—prioritizing among many good options. The latest update of their work expands this method with microsimulation modeling, and applies it to show the relative health impact and cost-effectiveness of preventive services for which the US Preventive Services Task Force found evidence of effectiveness.[16] These findings can be used by individuals, practices, and policy makers to focus attention on the preventive services that are most likely to make a difference.

Two additional papers use sophisticated microsimulation analyses to identify which preventive options for cardiovascular disease are most effective for the general population and for subgroups,[17] and to examine the separate and collective impact of brief clinician tobacco counseling for youth and for adults.[18]

Editorials by David Satcher,[19] George Isham and colleagues,[20] and Patrick O'Connor and colleagues[21] provide complementary and helpful perspectives in understanding this scientific evidence on prioritizing preventive services, and in applying it in policy and practice.

Also in this issue, a study by Saver and colleagues goes beyond the work of the National Commission on Prevention Priorities to address the difficult issue of assisting patients with making decisions about cancer screening that may seem beneficial, but actually have little known benefit. In a sophisticated randomized crossover study, they evaluate decision aids for controversial US Preventive Services Task Force recommendations surrounding prostate cancer screening for men and

mammography testing for women aged 40 to 49 years.[22] They find that the decision aid reduces intention to engage in screening tests with poor evidence of efficacy.

A CALL TO ACTION FOR PUBLIC SCHOOL TEACHERS AND PRIMARY CARE CLINICIANS

A Special Report by Saultz and Saultz, featured in *Annals* Journal Club,[23] highlights common ground between primary care clinicians and school teachers. Both fields are facing similar oppression from a top-down "measure and incentivize" culture that risks stomping out their personalizing work in caring for schoolchildren and patients. The authors identify alarming unintended consequences of performance management in both education and health care. These consequences of narrowing of purpose, de-professionalization, and loss of local/community control, are most likely to affect the most vulnerable.[24]

The article should shock policy makers into reexamining a measurement paradigm that increasingly is oppressing teachers and primary care clinicians, and for many children and patients, results in less effective education and health care. The Saultz paper is a call to action for the education and health care professions to rise up together for support rather than incentives. The paper emphasizes valuing personal, local knowledge, rather than disempowering it with impersonal measures, and calls for deeper understanding and support of the personalizing, integrating, prioritizing functions that frontlines teachers and primary care clinicians do every day while swimming against a stream of measurement burden that is often irrelevant and sometimes harmful.

PRIMARY CARE INFLUENCES

In the face of evidence that excessive interventions in the last 6 months of life are associated with suffering and unnecessary, unhelpful costs, Bazemore et al use national Medicare claims data to examine primary care physician involvement in the last 6 months of patients' lives. They find that greater primary care physician involvement is associated with less intensive end of life care, including lower expenditure, less intensive care unit days, and less hospice enrollment.[25]

At the other end of the age spectrum, an essay by Ungar uses recent neuroscience findings to link the "joyful bond that unites mother and infant" with early brain development and the opportunities presented by even brief health care interactions during well-infant and post-partum visits.[26]

Volkmann courageously shares her "experience as a survivor of sexual violence and as a provider for patients whose wounds from these traumas have flourished in atmospheres of shame and stigma."[27] Her deeply personal insights show how clinicians can help facilitate healing.

The preferences of mothers for vitamin D supplementation of their breastfed infants is ascertained by Thacher et al.[28] Most preferred to supplement themselves rather than their infants.

Trends in health information technology among small primary care practices are examined by Rittenhouse and colleagues.[29] They find increases over time in 16 out of 18 measures of health information technology functionality, particularly among hospital-owned practices, practices with 3 to 8 vs 1 to 2 physicians, practices with more Medicare patients, and those participating in pay-for-performance or public reporting of quality data.

We welcome your reflections at http://www.AnnFamMed.org.

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EDITORIAL

Perspectives in Primary Care: Family Medicine in a Divided Nation

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On November 8, 2016, family physicians went to work across the United States caring for patients. Some patients wore caps emblazoned "Make America Great Again" and others had buttons declaring "I'm With Her." As on any other day, the task was to care for each patient with respect and dignity. On November 9, the country awoke to a new president-elect. Half of voters were excited by the promise of a new administration leading the nation toward a greater future, and half were fearful of what lay ahead.

We do not pretend that all family physicians share the same political ideology. But we do believe that in a nation seemingly so at odds, family medicine can help heal the divide. The months preceding the election exposed many wounds. Unemployed and underemployed workers in the Rust Belt decried the departure of well-paying jobs. Videos streamed images of police officers killing unarmed African American men, provoking public outrage and movements to confront institutional racism. Dallas, Baton Rouge, and other communities mourned the premeditated killing of unsuspecting police officers. Immigrants found heightened cause to fear that their families would be wrenched apart by deportations. Individuals denounced the rising cost of insurance in an era of supposed affordable care. A fractious campaign culminated in an election revealing deep schisms based on geography, race, ethnicity, social class, and religion. Whereas 88% of African Americans and two-thirds of Latinos and Asians voted for Hillary Clinton, exit polls indicate that 58% of whites voted for Donald Trump.[1] Support for Trump was particularly high among whites without a college degree and among residents of rural communities. Highly educated city dwellers strongly preferred Clinton.

Although pundits portrayed the election as red state bigots versus entitled blue state elitists, family physi-

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