EDITORIAL

In This Issue: Communication in the Era of 'Personalized' Medicine

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Conflicts of interest: none reported

Ann Fam Med 2006;4:194-196. DOI:10.1370/afm.589.

COMMUNICATION

In this issue, we launch a new feature: the *Annals* Journal Club.[1,2] this new journal club takes a RADICAL approach, stimulated by the need for local forums to address important problems in primary care, and for a venue for interaction between these groups.

We initiate the *Annals* Journal Club with 2 qualitative studies that relate to patient perceptions of risk and the implication of these perceptions for communication. Frich and colleagues find that patients with familial hypercholesterolemia use a 2-step process to develop a personal sense of vulnerability to coronary heart disease.[3] Goldman et al study patients' reactions to 3 strategies for communicating risk and find that cardiovascular risk-adjusted age may be a useful strategy for communicating about risk and motivating behavior change.[4] As expectations grow about the ability to tailor diagnosis and treatment on the basis of genetic risk,[5-12] these front-line studies show the need to understand and include patient perceptions in any planning for (genetically) "personalized medicine."[13,14]

Both Goldman et al and Frich et al find that earlier-than-usual age at disease onset is a commonly understood indicator of risk for adult diseases. "Risk age," compared with chronologic age, can be a powerful, personalized way of communicating the impact of risk factors and of risk-reducing measures. Premature disease in a family (eg, a heart attack in a middle-aged person) can motivate preventive measures but might also let relatives who have outlived that age feel "exempt" from the risk or prevent younger relatives from engaging in risk reduction until they are closer to the age at which family members have been affected. A dialog focused on age may be a productive way for clinicians to discuss prevention with patients at risk.

Several other studies raise issues that relate to communication between patients and clinicians. Williams et al discover that among patients in Veterans Affairs general medicine clinics whose screening tests are positive for alcohol misuse, the majority are ready to change their behavior.[15] In addition, greater alcohol misuse severity is associated with greater readiness to change. These findings counter common stereotypes and should motivate clinicians to ask about alcohol use, to expect motivated patients, and to have systems available to follow up on positive patient responses.

In an international study that compares physicians in the United States and the Netherlands,[16] different physician perceptions of their role, family wishes, and knowledge of the patient may explain more aggressive treatment of demented nursing home patients with pneumonia. Thus, the personal, social/societal, and relationship context for communication and decision making can have profound effects on the kind of care that is delivered.

Finally, an essay depicts the transforming effect of a physician's limited ability to communicate.[17] The personal experience of the restrictive effect of communication problems leads to lessons about communicating with patients who don't speak the same language.

CESAREAN DELIVERY AND PATIENT CHOICE

In this issue, Zweifler et al report on the decline in vaginal births after cesarean sections (VBAC) in California.[18] They show that this trend was already underway before a change in American College of Obstetricians and Gynecologist guidelines that might have restricted access to VBAC. Leeman and Plante[19] write a provocative essay urging that systems of childbirth care preserve women's options to choose vaginal birth—eg, after a previous cesarean delivery—amid discussions of elective primary cesarean delivery without labor. In March 2006 the National Institutes of Health convened a State-of-the-Science Conference regarding Cesarean Delivery on Maternal Request (CDMR). The report of this conference, available at http://consensus.nih.gov/2006/cesarean-

DRAFT032906.pdf, confirmed the nationwide trend for decreasing rates of VBAC and the record-high cesarean delivery rate of 29.1% in 2004. The NIH panel concluded that the incidence of CDMR is unknown but probably contributes to the increase in primary cesarean births. They also concluded that there is insufficient evidence to evaluate its risks and benefits compared with planned vaginal delivery. The conference also proposed research questions to gather further evidence on this controversial topic.

ARTICLES OF POLICY, PRACTICE, AND RESEARCH INTEREST

In a case study of an interesting natural experiment, the leaders of 4 practice-based research networks with very different ways of organizing show how different initial conditions and processes for running a network are associated with different outcomes.[20]

In another natural experiment, Guirguis-Blake and colleagues[21] use the National Practitioner Data Bank to examine the effect of caps in total and noneconomic damages on malpractice insurance payments across all 50 states and the District of Columbia. Amidst wide interstate variation, caps on total and noneconomic damages are associated with lower malpractice payments. The findings provide support for the effectiveness of certain forms of malpractice reform on payments.

A systematic review by Gartlehner and colleagues finds benefit from inhaled corticosteroids for patients with moderate or severe chronic obstructive pulmonary disease, but not for mild disease.[22]

Lack of trust is at the heart of human participant protection and privacy efforts, laws, and regulations. A new measure of patient trust in medical researchers is found to have good psychometric properties.[23] The association with racial differences supports a large body of research showing that African American patients and many other minority groups have lower trust in researchers.[24-31] This lower trust is based on many historical and current reasons,[24,26,32,33] and is a major reason for lower participation of minority groups in medical research,[24,26,27] and the resulting limited relevance of much medical research to minority groups.[34,35] The development of a measure is a step toward furthering understanding and solution of this problem.

We welcome all *Annals* readers to participate in the online discussion of articles at http://www.AnnFamMed.org.

To read or post commentaries in response to this article, see it online at http://www.annfammed.org/cgi/content/full/4/3/194.

Acknowledgments: We are grateful to Esa Davis, MD, MPH, and Sonja Haywood, MD, for their help in preparation of this editorial.

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EDITORIAL

Annals Journal Club: It's Time to Get RADICAL

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Conflicts of interest: none reported

Ann Fam Med 2006;4:196-197. DOI: 10.1370/afm.588.

With this issue of *Annals of Family Medicine*, we launch a new feature to help readers build learning communities to improve health through enhanced understanding of primary care. We call it the *Annals* Journal Club, but this is not your old journal club. Rather, we encourage you to use this feature to develop your own RADICAL journal club. RADICAL is an acronym for Read, Ask, Discuss, Inquire, Collaborate, Act and Learn. We invite diverse groups, including students, residents, faculty members, practicing clinicians, health care workers, patients, and others to create forums for discussion and action.

Journal clubs have a long history as a structured forum to teach critical appraisal, transmit clinical information, and stimulate interest in research.[1-5] Journal clubs include many local adaptations, but those that enjoy high attendance and longevity are more likely to involve food, mandatory attendance, strong perceived importance by a leader, formal teaching of critical appraisal skills, an emphasis on original research articles, and promotion independent of faculty.[6,7] A recent systematic review identified 3 "best practices" for journal clubs: (1) use of a structured checklist, (2) explicit written learning objectives, and (3) a formalized meeting structure and process.[8]

These traditional approaches work well for many groups; however, the crises in our health care systems call for moving beyond tradition. It is time to use our evolving generalist evidence base to nurture the radical thinkers and leaders that must emerge if we are to build a future that assures equitable, quality, sustainable, personalized, integrated health care. The *Annals* Journal Club can be one forum where those who care will meet, share, learn and create change.

With each issue, the *Annals* Journal Club will select an article or articles and will identify questions to ignite reflection and conversation. We offer the *Annals* online discussion forum, called TRACK, as a way for local journal clubs to share their insights and conversation themes, and we will highlight commonalities or uniquely important ideas in our regular editorial synthesis called On TRACK. Comments submitted within 3 weeks after publication of an issue of *Annals* will have the greatest chance of being referenced in On TRACK.