On TRACK: 'Allows Readers and Authors to Go One Step Further'

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As noted by a recent participant, the *Annals* TRACK discussion of articles can be "a good forum for communication on publications, and allows readers and authors to go one step further."[1] Since the last issue, readers and authors have gone the next step in elucidating patient and clinician experience with nasal irrigation as a helpful treatment for chronic sinus disease. They advance our understanding of the "dance" between patients and clinicians regarding care of depression, pregnancy, and chronic pain. They reveal opportunities in the application of the chronic care model, in conducting home visits, and in using practice-level syndromic surveillance to link primary care and public health.

NASAL IRRIGATION FOR SINUS CHRONIC SYMPTOMS

The qualitative study by Rabago and colleagues kindled sharing of experience from family physicians, rhinologists, and a patient.[2] They endorse the efficacy of nasal saline irrigation for treating nasal symptoms, as well as identifying issues that require further research.[1,3-5] This discussion gives a number of practical tips and helpful references.

THE 'DANCE' BETWEEN PATIENTS AND CLINICIANS

Discussions of several articles provide insights into the need to understand the process of care and the clinician-patient relationship in order to improve care.

Regarding the multimethod study of how doctors and patients talk about depression,[6] Susman and Bogdewic each raise provocative questions:

"Do continuity and shared experience breed shared complicity in a carefully orchestrated dance that avoids challenging issues? Do physicians and patients self-select each other to achieve emotional equilibrium and avoid problems that might upset a forthright and stereotypical encounter? Is 'being a good patient' or 'they'll just send you to a psychiatrist' a learned response, a behavior modeled by physician cues? How accurately do doctor and patient assess each other's underlying motivations and preferred responses?"[7]

"The 'dance' between patient and physician over depression care involves the patient's views of their interactions with their physician, the actual dynamics of the encounter, and the physician's views of caring for depressed patients. How are the physician's views colored by his or her (a) own emotional/psychological well being, (b) skills for treating depression beyond prescribing medication, (c) ability to be reimbursed for exploring psychological issues when no diagnosis of depression is determined, (d) attitudes toward certain patients 'presentations' and (e) success rate in treating depression in a given population?"[8]

MODELS OF CARE

The challenges of implementing the chronic care model prompted readers to share their interpretations and experiences.[9,10] One reader experienced the initial resistance to change found by Solberg and Hroscikoski,[11,12] but discovered that the picture looks more positive after 5 years of follow-up.[13] A 1-page, color, patient diabetes care progress report improved care and made clinical life easier to such a degree that physicians were willing to underwrite the $1,500 per year cost.

An experienced clinician[14] and a study author[15] in dialogue hypothesize that a major reason for positive outcomes from prenatal care may be that it provides a vehicle for developing a clinician-patient relationship prior to a key life event.

A Nigerian psychiatrist notes, "Chronic pain frequently occurs in the context of inter-connected social, emotional and cultural factors.... However, patients with chronic pain also may have multiple psychosocial problems which are not necessarily classifiable in the form of discrete psychiatric disorders."[16] He notes that

interventions[17] must address these often unclassified psychosocial issues to be effective.

Other discussion raises the question of whether systems of health care should mandate a usual source of care or whether patient choice alone should determine whether patients have a medical home.[18,19]

The essay on home visits by Landers[20] resonated with the experience of a recent trainee[21] and experienced physician leaders of the field of family medicine,[22,23] while stimulating questions about the feasibility of the business model.[24]

A study showing the feasibility of using surveillance of rates of clinical syndromes to identify emerging infections[25] showed one reader a method for "routine, rapid, and meaningful interaction between primary care providers and public health."[26] Another expert reader identified an opportunity for coordinating with other national surveillance systems.[27]

Further discussion of the comparison of differences between Dutch and American physicians in treatment of demented nursing home patients with pneumonia show that what one culture dismisses as paternalistic models of care can potentially provide value within the context of established relationships among physicians, patients, and families.[28,29]

Finally, authors responding to online comments sound a cautionary note to the movement toward patient-choice cesarean delivery, noting the insidious effects of adopting unproven obstetrical interventions.[30]

Please join the discussion at http://www.AnnFamMed.org.

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