ON TRACK

A Healthy Conversation

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ARE WE ON TRACK?

The *Annals of Family Medicine* aims to serve a worldwide community of inquiry in primary care. We have combined 2 technologies—e-mail and electronic publishing—to provide an innovative system for electronic letters commenting on the original reports we publish. This system, called TRACK (Topical Response to the *Annals* Community of Knowledge), stimulates and sustains a conversation among readers, authors, and other interested parties on the research and the issues it raises. In each issue, the *Annals* editors also provide this column, called On TRACK, which highlights key points raised in the TRACK discussion. This time, we ask you to comment on the On TRACK feature itself. Do these summaries add value to the *Annals* for you? Are the editors' comments and the hot links to the articles and comments useful to you? Please share your thoughts by posting a TRACK comment to this column at http://www.annfammed.org/cgi/eletter-submit/6/4/370. We welcome suggestions for improvement in the TRACK system of eletters or the On TRACK columns. As with all TRACK items, your comments will be published in the online *Annals* for all readers to see and cite. Thank you.

A SYSTEM FOR US HEALTH CARE

The essay by Devoe entitled "The Unsustainable US Health Care System"[1] brought reflections from readers on the pain the current chaos in health care causes both patients and clinicians. Several readers pointed to the blueprint that already exists for building the system we need, a single-payer system, as proposed by Physicians for a National Heath Plan (PNHP).[2-5]

John Geyman made the case:

> We need to deal with the elephant in the living room—the failing private insurance industry. Incremental efforts to reform health care over the last 30 years…have all failed to improve access to affordable health care.… The most important policy question now facing us is whether or not to retain private multi-payer financing. Based on its failed track record, we now need to discard this obsolete industry and rebuild US health care on a single-payer public financing system…coupled with a private delivery system.[6]

Jenkins advocated "a government run single payer system with PRIVATE delivery of medical care," and reminds us that, "recent polls show [that over] 50% US physicians favor single payer." "We don't need to reinvent the wheel…. We now have an EVIDENCE BASED outline about how to do it."[3]

Reflecting on his current practice in a Federally Qualified Health Center, Saver reported on the Massachusetts experiment with universal health insurance:

> [P]roviding insurance alone isn't enough…. I am aware of only one intervention with the potential to save enough money to keep our health care system solvent—a single-payer system. …[O]ur current system has no clothes because we prefer to drape the insurance industry in furs and silks.… [T]he only affordable, sensible, and equitable solution is a single-payer, universal system. Then we could move on to reforming provider payment, shoring up primary care, and trying to make medical practice more evidence-based and cost-effective.[5]

Lesser also reported problems with the Massachusetts program and urged physicians to sever ties with the insurance and pharmaceutical industries.[7] Other comments emphasized delivering added value through the medical home model[8] and reducing waste by getting "our own house in order."[9]

RELATIONSHIP, COMMUNICATION, AND ADHERENCE

Relationships are central to primary care. The study by Street et al on "Understanding Concordance In Patient-Physician Relationships"[10] drew comments connecting the findings with physician persuasion,[11] patient adherence, and health disparities. Kravitz called for more research to focus on "the most important question of all: Does this physician make you feel cared for?"[12] Fiscella stressed the "important implications for patient-physician communication across differences in race, ethnicity, age, gender, and social class"[13]:

The findings suggest that what matters to patients in terms of satisfaction, trust and intent to adhere is whether the patient perceives the physician as similar in terms of values and beliefs. …[F]actors such as supportive communication and partnership building are associated with patient perception of affinity. Improving these skills represents a potentially important strategy for addressing disparities in health care outcomes.[13]

Adherence—this time, physician adherence to clinical practice guidelines—was the topic of the study entitled "Physician Response to a Community-Level Trial Promoting Judicious Antibiotic Use" by Stille and colleagues.[14] Stein et al emphasized the complex and dynamic context of the antibiotic resistance problem. He asked us to recognize that,

…when it comes to antibiotics, the implications extend far beyond the individual, and into the community; also, they are substantially different than for other pharmaceuticals, because resistance affects people who were never exposed to the antibiotic.[15]

Scott called for the addition of qualitative methods to prescribing research. "Knowledge is not enough" to change prescribing behavior:

Future interventions to decrease inappropriate antibiotic prescribing should target not only knowledge, but also patients' mental models of illness and should take into account the complex mutual influence that occurs in clinician-patient interactions.[16]

OTHER THREADS OF TRACK DISCUSSION

In a poignant essay, Dr Middleton shared her grief on the suicide of a physician colleague,[17] moving several readers to reflect on similar tragedies.[18] Dr Schwenk pointed to how the stigma of depression in doctors complicates care.[19] Most believed that we bear a special responsibility for the depressed colleague or the physician-as-patient, but one reader took a nihilistic view: "As physicians we are trained to feel as though we are responsible, which although it is noble, it is also controlling. Control is an illusion, and death is inevitable, the rest is all about timing."[20]

Fisher reported on a new questionnaire to screen for "diabetes distress,"[21] which elicited comments on the burdens patients experience with chronic illness and its management.[22] This distress appears to be separate from depression and calls for different measures to recognize and manage it.[23] Crownover stressed how this new screening tool would fit into team care or group appointments in the management of diabetes and the associated emotional problems.[24]

The conversation continues about the challenges of adapting practices to deliver integrated chronic illness care in response to the report by Russell and colleagues, "Beyond Fighting Fires and Chasing Tails?"[25] Mott described experience with practice innovation in Australia and concluded that to be successful, it must be system driven, profession driven, patient driven, and practice driven.[26]

A WORLD OF CONVERSATION

TRACK comments cover the broad range of topics addressed by the articles in the *Annals of Family Medicine*. The conversation also involves a diverse range of voices and views. Just in the last month since the May/June issue, about one-half of the comments have been contributed by family physicians, about three-quarters of those in academic settings and one-quarter in community-based practices. The other half of comments came from a mix of people in other primary care fields, clinical subspecialties, biomedical sciences, public health, and management. Ten percent of the comments come from readers in Canada and Mexico. Another 20% live outside of North America, mostly in Europe and the Antipodes. In response to recent issues, comments have included the voices of patients, payers, and policy makers; of advocates and organizations; of critics and cranks. Each piece of research, reflection, or theory is a new opportunity to engage a world of experts.

Please join the TRACK discussion on any piece published in the *Annals* at http://www.AnnFamMed.org.

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CORRECTION

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Spiegelhalter DJ. Understanding uncertainty. *Ann Fam Med.* 6(3):196-197.

In the print version of the May/June 2008 *Annals of Family Medicine,* the editorial by Speigelhalter refers to an article entitled "Patients Prefer Pictures to Numbers to Express Cardiovascular Benefit From Treatment" as authored by Chan et al. The correct attribution is Goodyear-Smith et al. The print version therefore departs from the online version.