ON TRACK

Multidisciplinary Discourse

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The online discussion since the last issue includes thoughtful analysis, multidisciplinary discourse, and interactive reader-author dialogue. It also includes some analyses and calls to action that may be shocking to some, resonant truths to others.

DIZZINESS

In a multidisciplinary discussion, including insights from a RADICAL journal club,[1,2] the challenges of diagnosing the causes of persistent dizziness in the elderly are brought to light. These challenges include attributing causality among many comorbid conditions and discerning risk factors from causes.[3-6]

DEPRESSION, PAIN, AND TALKING WITH PATIENTS

The dialogue around a study of how depression-screening instruments are reinvented in their actual use by primary care clinicians[7] beautifully articulates the tension and complementarity between using nuanced individual approaches and setting up systems to routinely deliver needed screening and care. Richard Brown[8] notes,

> We primary care clinicians are scrappy and brilliant when it comes to managing individual patients. It's sad that most of us don't do nearly as well at crafting practice systems that would systematically help many more patients.

In a related comment on a different article,[9] an experienced measure developer[10] lauds the elegance and practicality of a parsimonious new instrument that screens for 4 common mental health disorders.

Like[11] identifies helpful online resources for cross-cultural care of patients with depression, and reminds us of "the variety of ways in which physical and psychological pain and suffering are expressed in multicultural communities." He goes on to note,

> We also need to move away from solely employing "deficit models" in understanding illness and disease, and examine the "assets, strengths, and resilience" that many refugees bring during the migration process to their new host countries.

A consumer advocate[12] adds a complementary perspective on the ethnic interpretation of depression, visualizing depression under "two subheadings: independent of time, place and culture, and dependent on time, place and culture." Bichara asks us to "simplify the condition by using simpler terms such as 'sad,' 'worry' or 'stress'; then it becomes easier to work with, manage, or overcome." He goes on to suggest:

> The actual talking with someone is most therapeutic in overcoming sadness, worry or stress…. I do see that the best form of treatment is the dialogue: the process of the dialogue exchange and negotiation, the laughter generated, the happiness in giving someone an opportunity to voice themselves and arrive at a solution to their sad state, their worriness, or their state of bewilderment.

Swindell and colleagues' article on beneficent persuasion[13] elicited 2 important alternate perspectives from observers and participants in the end user's side of health care. Weil[14] cautions about "the inevitability of personal bias—it's certainly not just on the patient side." She notes that clinician's bias and persuasion can cause harm as well as good. Also causing clinicians to question our biases, Dewid[15] identifies,

> …[what patients] want when we need help with our discomfort/dis-ease and turn to the medical community…. Among our needs are: Relief of pain. Resumption of activities. Stem loss of wages or missed commitments. Stem loss of image, strength, dexterity, competitiveness, self esteem, etc.…

On an editorial note, I can't help but reflect how sterile and far away from Dewid's articulation of what patients want are most of the quality-of-care measures currently in use, and how far from this is the dominant measure of the patient-centered medical home.[16,17]

Rosenblatt[18] notes that "drug-seeking patients are one of the most disruptive and disturbing parts of primary care practice." He goes on to observe,

> …while opiates are a crucial part of taking care of patients who have been acutely injured, are recovering from a surgical intervention, or have chronic pain due to cancer, they are a dismal failure in treating chronic pain for the vast majority of patients whose discomfort stems from other causes.

He suggests greatly limiting the use of opiates for patients with chronic noncancer pain.

THOUGHTFUL DISCUSSIONS

A number of articles stimulated thoughtful discussions on diverse topics, including the causes and implications of trends in well-child care by family physicians[19]; using participatory approaches to promote sustainable, translatable research relevant to improving health[20]; deciding how we might use C-reactive protein to reduce and tailor antibiotic use for respiratory tract infections[21]; reframing how decisions are made about colorectal cancer screening[22]; reminding us with specific examples that "our results depend on what we decide to count"[23]; and an author answering numerous reader questions about a study of how patients ask questions during outpatient visits.[24]

A very interactive discussion[25] about collective learning in communities of practice[26] yielded a primer and useful references on the application of systems and complexity science to collaborative care of patients with multimorbidity.[27] This discussion with the author expands understanding of how communities of practice and leadership may work to balance cooperative and competitive behaviors to enhance care of people and populations.[28,29]

CALLS TO ACTION AND UNDERSTANDING FROM THE EDITORIAL SERIES

The conclusion of the editorial series on integrative approaches to promoting health and personalized, high-value health care stimulated some big-picture comments.[30]

Pretorius[31] notes,

…family physicians frequently use a different mental construct for thinking about patients—a process that includes aptitude in complexity, ambiguity, undifferentiation, prioritization, integration, value clarification, conflict management, empiricism, collaboration and teamwork. Additionally, family medicine from its inception has further defined itself by its relationships: patients, spouses, children, extended families, communities, public and global health.

Meyers and Clancy[32] note the resonance of the mission of the Center for Primary Care at the (US) Agency for Healthcare Research and Quality with the timeless concepts re-articulated in the series:

- We agree that reforming our health system will require transforming our primary care health system and that this will require workforce development, alignment of reimbursement and incentives, and expanded roles for primary care teams.
- We are committed to envisioning, developing, and implementing a new generation of health information technology that supports generalist functions—systems that allow clinicians to see connections, prioritize, and understand the needs of communities.
- We echo the call for a new generation of quality measures that balance more narrow process measures with more global outcome measures and new measures that reflect the value of the whole-person integrative functions of generalist care and that measure quality for complex diseases, patients, and populations.

As partners with the many stakeholders involved in these complex opportunities, we pledge to embrace the generalist approach and remain humble, connected, and open. We know that many are ready to join us and that together we can improve health and health care for all Americans.

Bodenheimer[33] summarizes themes from the series and presents a challenge for developing innovation and renewal within the falling US empire. He summarizes:

Healing requires not simply disease-focused evidence-based medicine but meaningful relationships in which physicians know their patients as people. The worsening fragmentation of medicine destroys those healing relationships. Generalism is a way of thinking required for the development of healing relationships. Primary care faces a paradox in which specialist care is better for specific diseases but primary care is better for the health of individual people and populations. We embrace team-based care (moving from I-knowledge to we-knowledge), but need to address the reality that, compared with care provided by the physician alone, teams may dilute continuity of care. Modern medical care is progressing in its smallest units—the gene, the enzyme, the cell—but downplays the importance of its largest units—the health of the entire population. Social systems evolve in cycles, and the US health care system may be awakening from a dysfunctional stage toward a period of turbulent renewal; primary care is positioned to lead this renewal process.

Bodenheimer goes on to observe and challenge:

[T]he United States is an empire in decline…. When empires fail, bad things happen internally. For the US, the internal sickness is accelerating quite rapidly. Gridlock in Washington reveals a paralysis of government even in the face of fiscal unsustainability. The widening of the gap between rich and poor, which worsens health care disparities, is related to endemic corruption and selfishness and a refusal of higher income people to pay their fair share of taxes.

Within health care, the "look out for yourself and screw everyone else"—so characteristic of a declining empire—is shown by the drive by specialist physicians, hospital systems, and suppliers to "get what we can while it lasts" attitude.

Does that mean we should just give up? Join the "get what we can" philosophy? Despair the inevitable? No, no no. First,

we don't know how long the decline will take…. Whatever the timescale of events, we can celebrate that even within a declining empire a thousand local flowers can bloom, and they are blooming in primary health care. The primary care innovation taking place represents the upswing of a renewal cycle within health care which can proceed even within the downward trend of society. Another reason to keep active is that the worst internal strife characteristic of some empires in decline can be avoided by a population that supports a national leadership with the moral strength of a Ghandi or Mandela, allowing the nation to experience a soft landing rather than a violent crash.

Upshur[34] questions whether physicians have or need moral authority. Building on the recent ethical analyses of Marcum,[35] Upshur notes,

…virtues such as curiosity, humility, honesty and courage are linked to both theoretical and practical wisdom in clinical practice.… [P]erhaps what needs to be cultivated is a greater attention to practical wisdom, which may give moral legitimacy as well as authenticity.

Katerndahl, Sturmberg, and Martin[36] explicate,

…[a] complexity science lens that permits us to visualize the interconnectedness, diversity, and interdependence of health, health care and healthcare organizations to recognize the opportunities for change inherent in all complex adaptive systems.

Bagley[37] witnesses:

The right question for the patient with fatigue is, "What is going on in your life?" The physician must be thinking "What is making this person sick?" or "Why do they need to be sick?" After you have gone through that exercise then it is OK to check for anemia. Fragmentation is largely the result of our payment system. "I got my portion of the payment, now you get yours." Nothing about our current system fosters a shared responsibility for cost and quality. It certainly does not reward in any significant way, the critical ingredient that is a continuous healing relationship between patient and clinician or care team.

Green[38] concludes "that the profession of medicine in the United States no longer lives with 'congruence between thought, word, and action.'" He goes on:

This is serious. Once we physicians know something important that needs attention, it is not proper to remain passive and silent. Particularly for family physicians and their primary care friends, what's next?

This article[39] claims that: "Biomedical health care can foster moral authority when it moves beyond clinician-centered care to patient-centered care to relationship-centered care to goal-oriented care. Each step in this path transcends and includes the one before." The struggle to get to patient-centered care is tough and not a done deal. Nonetheless, maybe it is time to focus on the actions needed to assess this sequence and devise strategy to move along this sequence. If the country allowed us to do so, would we family physicians deserve an opportunity to learn how to be the best personal physicians possible in the information age, operating on a transformed platform of integrated health care? I think the answer can still be a hearty, "yes!!"

Please consider joining the discussion at http://www.AnnFamMed.org.

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CORRECTION

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Evaluation of the Ameican Academy of Family Physicians' Patient-Centered Medical Home National Demonstration Project. *Ann Fam Med.* 2010;8(Suppl 1):S1-S92.

After the "Evaluation of the American Academy of Family Physicians' Patient-Centered Medical Home National Demonstration Project," went to press, we became aware that the links to the articles' supplemental data were displayed incorrectly. We were able to repair the links online, but the print version of the supplement contains data links that will not work if they are used to find the supplemental data to the articles. The correct display of a URL for a supplemental data link should be as follows: http://www.annfammed.org/cgi/content/full/8/Suppl_1/S<first page of the article>/DC1, in which both the "s" in Suppl and the "s" before the page number are capitalized.