ON TRACK

Courage and Change

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Recent comments in the *Annals of Family Medicine's* online discussion underscore the importance and pervasiveness of change in 21st century primary care practice. These comments shed light on efforts to bring technological change to overburdened practices as well as the "courage to make necessary changes"[1] to bring equity to health care.

Several articles in the January/February 2011 issue of *Annals* reported studies from the rapidly changing world of office-based technology. Comments on those articles reflect the complexity of such endeavors. A study of an electronic health record (EHR)-based diabetes decision support tool led readers to varying conclusions.[2] According to one comment, the lesson of the study pertains to facilitating clinicians' actions rather than their decision-making processes: "The take home point of this intervention…is not that clinical decision support improves care. Rather, it is that diabetes management can be improved through re-engineering the clinical workflow to include an end-of-visit care plan assessment."[3] Another comment found a lesson in the potential of the decision support tool to strengthen communication by "engaging the patient in a 3-way doctor/patient/computer conversation…with careful attention to implementation planning, provider training, and user-centered information system design, such conversations can improve the quality of the encounter."[4]

Another recent study raises broader questions about the potential of EHRs to improve quality of chronic illness care. The study of EHR-based clinical decision support for NSAID (nonsteroidal anti-inflammatory drug) guidelines[5] suggests that "health IT [information technology] is not a panacea. EHRs don't magically improve care, even when used appropriately and with deliberate attention to detail by doctors who care enough about their outcomes to study them carefully."[6] The authors concurred, noting that "most EHR-based CDS [clinical decision support] is not well suited to fit seamlessly into the clinician's workflow."[7]

Readers were enthusiastic about a study of a Web-based tool to screen for family history and tailor prevention messages and its findings that familial risk may motivate health behavior change.[8] Reader comments remind us, however, that a good tool supplements and strengthens, but does not fully replace, clinical judgment and expertise.

> … the need for individualized risk-based screening regimens based on family health history is clear. But there always remains the nagging question, isn't it simpler and just as effective to aggressively promote a healthy lifestyle in all our patients regardless of their family health history for common disease?[9]

> … much of the art of medicine comes into play in how a physician interprets the family history information. Sure we give standard messages about exercise and nutrition, but don't most of us tailor the message based on the patient's sociocultural background, educational level and the patient's own context with regards to illness?…If we can implement this tool widely, it will force physicians and those of us who teach physicians to learn the process of effectively communicating risk to patients....[10]

Compared with technological change, which is in full swing, meaningful national health policy change is in its early stages (at least in the United States). An essay by Fiscella[11] described how recent health care reforms could address disparities in care. Indeed, according to one commenter, US health care reform legislation does have the potential to "create an environment in healthcare that is conducive to eliminating biases."[12] Such an environment will only be created, however, if Americans commit to a challenging and widespread process in which,

> …policy-makers, administrators, healthcare professionals, and the general public [are] willing to engage in unguarded introspection and honest dialogue about the hidden anxieties, conscious and unconscious biases, and individualistic values that drive our decisions, as a society, about health resource allocation. Overcoming these difficulties will also require courage to make necessary changes…and commitment to stay on track regardless of the obstacle course we must navigate.[1]

Another commenter suggests that the essay can serve as a springboard to address related issues requiring change, including the difficulty in obtaining specialty

care for Medicaid patients, the need for culturally sensitive community engagement in health care settings, and the importance of health care at both individual and population levels.[12]

An update from the Association of Departments of Family Medicine[14] called for concrete action in addressing the future of primary care in Academic Health Centers (AHCs). According to the article, as medicine undergoes dramatic reforms, AHCs risk becoming "niche providers…with seriously weakened research and educational capabilities"[13] if they fail to recognize primary care's vital role. A response from the Association of American Medical Colleges states that although its members recognize the value of primary care and community medicine, "the academic medical community still has much work to do in order to be fully ready for reform…."[14]

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References

1. Cooper LA. Health care reform provides momentum to reduce institutional biases [eletter]. http://www.annfammed.org/cgi/eletters/9/1/78#20964, 30 Jan 2011.
2. O'Connor PJ, Sperl-Hillen JM, Rush WA, et al. Impact of electronic health record clinical decision support on diabetes care: a randomized trial. *Ann Fam Med.* 2011;9(1):12-21.
3. Grant RRW. Decision support vs re-engineering workflow [eletter]. http://www.annfammed.org/cgi/eletters/9/1/12#20286, 18 Jan 2011.
4. Ash JS. Clinical decision support for diabetes care [eletter]. http://www.annfammed.org/cgi/eletters/9/1/12#20949, 26 Jan 2011.
5. Gill JM, Mainous III AG, Koopman RJ, et al. Impact of EHR-based clinical decision support on adherence to guidelines for patients on NSAIDs: a randomized controlled trial. *Ann Fam Med.* 2011;9(1):22-30.
6. Kibbe DC. A valuable contribution [eletter]. http://www.annfammed.org/cgi/eletters/9/1/22#20270, 18 Jan 2011.
7. Gill JM. Response to Dr. Kibbe regarding EHRs and clinical decision support [eletter]. http://www.annfammed.org/cgi/eletters/9/1/22#20489, 20 Jan 2011.
8. Ruffin MT, Nease DE, Sen A, et al. Effect of preventive messages tailored to family history on health behaviors: the Family Healthware Impact Trial. *Ann Fam Med.* 2011;9(1):3-11.
9. Stehney MA. It's nice to have some evidence [eletter]. http://www.annfammed.org/cgi/eletters/9/1/3#20724, 22 Jan 2011.
10. Martin JR. Family history is all about the family [eletter]. http://www.annfammed.org/cgi/eletters/9/1/3#21101, 1 Feb 2011.
11. Fiscella K. Health care reform and equity: promise, pitfalls, and prescriptions. *Ann Fam Med.* 2011;9(1):78-84.
12. Andrulis DP. Health care reform, the primary-specialty care link and the centrality of community [eletter]. http://www.annfammed.org/cgi/eletters/9/1/78#21212, 3 Feb 2011.
13. Robertson R. Academic health centers: will they survive? *Ann Fam Med.* 2011;9(1):90-90.
14. Conroy JC. In response to editorial, academic health centers: will they survive [eletter]? http://www.annfammed.org/cgi/eletters/9/1/90#21374, 7 Feb 2011.