ON TRACK

The Conversation Continues, as It Should

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In response to the article on using oral steroids as a diagnostic test to distinguish between chronic obstructive pulmonary disease (COPD) and asthma by Broekhuizen and colleagues,[1] the discussion turns in part to one of nosology, as Hahn puts it: when, along the continuum of a lifetime of lung disease, do asthma and COPD become part of an overlap syndrome in which "pure" asthma can evolve into "pure" COPD over time?[2] Boundaries in clinical medicine are often, if not always, fuzzy, and using steroids to distinguish between 2 clinical entities, where steroids have an effect in both, is not helpful. As Crownover mentions, the situation is particularly vexing when an empirical trial of steroids for treatment, which is recommended in some guidelines, rather than diagnosis confounds the issue.[3] The anti-inflammatory effect of steroids can help in infection as well as reactive airway disease. Furthermore, Van Schayck points out that there is very little indication for inhaled steroids, and they should not be confused with oral steroids for management in situations where there is not a clear diagnosis of asthma.[4] All respondents agree on 2 points: the standards for management are neither clear or gold, have to do with the populations of patients in whom they are developed, and are not simple in what is often a mixed disease state. More primary care based studies should help management at that level.

The description by Coppin and colleagues[5] of irrigation of ears for wax buildup as a preventive measure to decrease clinic visits got the attention of a number of respondents who wanted to know whether the composition of the ear drops was specific and reproducible.[6,7] McCarter speculated that plain water might be just as good[8] but reminded me of what I was told by a teacher that, whether with plain water or the "ear drops" in this study, the last thing one should do is leave an ear canal wet, so a drying agent should be in order in all cases. Bartels suggested a proprietary preparation that is on the market.[9] My mother used olive oil, and a patient recently mentioned "sweet oil" but wasn't clear when I enquired just exactly what sweet oil is. Although Bartels' warning of possible mechanical trauma made me remember another admonition "not to put anything sharper than your elbow in your ear canal," I suspect that gentle lavaging with a low-pressure bulb syringe, as Coppin mentions, is low risk for trauma, given the lack of any adverse consequences in their study.

The article by van der Wel and colleagues[10] on the serial office measurement of blood pressures in a relaxed environment drew 2 thoughtful comments that should be considered when implementing a process in one's clinic to follow the guidelines in the article. Myers challenged, based on his data, the need for a 30-minute period of measurement and argues for a shorter period of time with more frequent measurements. As he writes: "Thirty minutes is too long to be feasible for routine clinical practice."[11] Verbek goes over a great deal of the information on ambulatory blood pressure measurement in the literature and suggests that home monitoring might have some value in contrast to the study in the *Annals:*

> Seen in this context one might consider performing self-measurement of BP instead as this leads to more measurements on separate days and might reduce the substantial burden for healthcare workers and patients when leading to less clinical visits.[12]

So, take your choice—rely on shorter periods of measurement to fit a more realistic office setting or have patients measure themselves to avoid unnecessary office visits. Van der Wel responds to both in an equally thoughtful manner.[13]

In a commentary on Wilkinson and colleagues' study[14] on obstacles to mammography screening in women with intellectual disabilities, Miller and Li raise the important and difficult point of informed consent for screening of all types for people with disabilities. As they mention, in their practice, most patients are in group homes with caretakers, a population that may differ from the patients in the study, who appear to be more independent.[15] In any case, Wilkinson agrees, and the patients in their study were consenting to the study, not the mammograms; informed consent, she agrees, will continue to be important to sort through with patients who may or may not understand general recommendations for screening.[16]

"'Trust' is clearly a many-splendored thing—and a difficult idea to quantify. I'm not sure the authors have

quite got a handle on it in this scale. But I definitely think this is a topic worth pursuing."[17] So writes Jessie Gruman from the Center for Advancing Health in a very personal commentary on the article by Thom and colleagues[18] on the development of an instrument for measuring the physician's trust of their patient. In addition to the very quantitative measurement in the *Annals* article, Kramer adds a comment suggesting that "psychological safety" is an essential component to the discussion of trust:

In climates characterized by high psychological safety, Edmondson [whose research Kramer cites] has shown across a variety of settings (including medical), individuals are more likely to appropriate help, useful diagnostic feedback, self-disclose their concerns regarding possible errors or perceived problems, and engage in more creative, collaborative problem solving.[19]

A scale may be important but perceptions are everything.

Finally, the article on the Ontario Family Health Team model of organizing and paying for primary care[20] drew a number of comments and insights from luminaries in both Canada and the United States who are looking for ways to operationalize medical homes. Carol Herbert, former dean of the University of London, Ontario, says it best:

Research findings to date support the FHT as a model that provides incentives to achieving patient-centred care. It is a model that makes it possible to answer a generation of disappointed and frustrated family practice graduates who have come back to us, their teachers, to say they cannot practise the way they were taught in their residency programs—the system doesn't let them…. Previous experiments, such as community health centres in the 1970's, were criticized because of decreased throughput. In this round of experimentation, we must determine what is the gold standard for number of patient visits just as we must monitor the reward systems to ensure that "pay for performance" does not become a perverse incentive.[21]

And Carlos Jaén, from the United States, commenting on lessons learned from the practices in the National Demonstration Project on the PCMH writes:

Advanced Primary Care systems (such as the PCMH and FHT) are front and center as a sure way to achieve the Triple Aim (higher quality, lower cost and better patient experience). However, we fool ourselves if we want to implement them in the absence of payment reform, without regional support for bringing more clinicians to the front lines, local control in the allocation of resources, and EHRs that work and talk to each other. The NDP practices remind us that it is possible to implement most of the elements but more support is needed.[22]

Amen.

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