ON TRACK

'The Expert … Is the Patient in Front of Us'

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The *Annals of Family Medicine* seeks to serve its community by publishing work that is original and useful, and by fostering conversation that is critical and creative. The conversation takes place on the Internet at www.annfammed.org. It involves readers like you. The July/August 2003 issue of the *Annals* (Vol. 1, No. 2), published papers that stimulated several interconnected TRACKs of conversation.

The study by Grumbach, Hart, and colleagues[1] documented that family physicians are more likely than other primary care physicians to provide care to underserved communities, and that physician's assistants and advance practice nurses are playing important roles. Recognizing the compelling policy implications of these findings, Rosenblatt[2] calls for implementation of personpower strategies as "relatively inexpensive ways to affect access to health care . . . , particularly given the failure of attempts to craft universal health insurance." Rabinowitz[3] agrees that "there is more than enough 'evidence' about what to do in order to better address this problem" of disparities in access to health care. He specifies "programs that provide preferential admissions . . . , clinical experiences, and financial and practice support." Rabinowitz calls for cooperative strategies: "Those who are underserved need all the help they can get – from all types of primary care providers! And primary care providers will have more clout if they address these issues cooperatively."

Making innovative use of the ecology of medical care model pioneered by Kerr White more than 40 years ago,[4] Fryer and team[5] showed that lack of primary care is associated with lower use of most medical services except emergency care, and that uninsured patients are more adversely affected. The editorial in the same issue by Dr. White,[6] himself, reminds us that our studies are limited by the data we collect and our views of health and care are constrained by the systems we use for classification of problems and services. He calls for use of the primary care-oriented classification systems, such as ICPC (International Classification of Primary Care[7]), that have proved their utility around the world in investigating the natural history of illness and the process of care. Immediate opportunities exist to coordinate and improve the major US government-funded studies, such as the Medical Expenditures Panel Survey (MEPS), used by Fryer et al.

An array of online discussants from Amsterdam, Rome, and Helsinki point out the failings of current US coding systems and the greater utility of systems in use elsewhere. Okkes[8] warns that MEPS data "substantially underrepresented" important chronic diseases in primary care that have been captured in other countries. She calls for adoption of systems to provide primary care researchers "the data they would deserve to have: episode oriented data routinely collected by US family doctors who are equipped with an electronic health record that is based on patients' problems over time rather than on utilization." Lamberts[9] emphasizes that current US coding systems make it "close to impossible to effectively take the patient's problem as the starting point, and to develop an episode of illness and an episode of care model." He decries the recent choice of "Snomed-CT as the standard vocabulary for the US, because it can greatly harm the family practice perspective in health information systems that will be introduced on a large scale in the near future." The development of electronic health record systems in the United States promises an "avalanche" of data, but Lamberts fears that, unless ICPC and other standard international coding systems are adopted right now, "the curtain will fall for family practice research with routine EHR data." Kalimo and Purola[10] remind us that "health care actually is a social phenomenon" and join the call for adoption in the United States of information systems based on "the care of the health of individuals and the associated health policy arrangements—and not only to the diagnosis and cure of a disease."

Disparities in health are associated with disparities

in education, and the study by Fiscella and colleagues[11] showed that such differences in preventive care are buffered by HMO participation. Weiss[12] notes that health literacy might be more critical than educational attainment. Green[13] points to the growing body of evidence that planned systems of care[14] have many benefits. "These integrated systems are an integral part of 'reaching' and 'delivering' important care services and it remains a strategic challenge as to how to integrate these services in less organized care systems."

Becker's qualitative study[15] of cultural expressions of bodily awareness among chronically ill Filipino Americans elicited comments on method and content. "Tantalized" by the approach and findings, Culhane-Pera[16] asks for further help from medical anthropologists: "How do I apply this information to the clinical setting? What format works best, and what doesn't work? And does culturally responsive care make a difference in health outcomes?" She asks "anthropologists to be co-researchers on the team with primary care providers and community members, engaged in community-based participatory action research." Shore[17] adds insights from more than 25 years of clinical experience with similar patients and suggests, "A next-step study could be an investigation of effective strategies to increase dietary adherence for chronic illnesses." Saba[18] urges, "striking a balance between diversity and commonality. . . . Clinically, we should be careful not to assume that all people hold the same value, but inquire about how they respond to a value that is common in their culture . . . . The expert on what is culturally important in clinical care is the patient in front of us."

Conversations continue on topics raised by articles in the first issue of the *Annals.* Similarities between the low cesarean rates reported by Leeman and Leeman[21] in a Native American community in the southwest United States, and those found by North[22] years ago prompt Dr. North to suggest the importance of stable factors, such as cultural attitudes, organization of care, and genetics. Other discussants report achieving low cesarean rates with childbirth services organized around primary care. Authors Leeman and Leeman[23] respond in depth to the many TRACK comments their study generated and express "concern for the loss of rural VBAC (vaginal birth after Cesarean) access."

Responding to comments on her study of barriers to self-care by persons with comorbid chronic diseases,[24] Bayliss[25] discusses how depression complicates both clinical care and research with patients with multiple problems. "(S)ocial factors affect not only barriers to the self-management of disease, but to the self-management of health as well. We would do well to remind ourselves of the well-worn (but very relevant) term 'biopsychosocial' assessment as we care for persons with multiple illnesses."

The compelling essay and paintings, "The Face of Cancer" by patient Crommet and physician Scott[26] evoked praise, passion, and personal stories. Schueler[27] gives testimony from experience as a professional patient advocate. "Top Gun" consultants have their place, he says, "But when it comes to the long haul, my patients prefer a relationship with a physician who is knowledgeable yet able to hold their hand at the edge of the abyss, to respect their humanity and wholeness apart from their disease, to rework the map when the terrain changes, and to cry and laugh as part of the compassion and renewal which is embodied in that special relationship between a physician and a patient." Maryman,[28] herself a breast cancer survivor and a family physician, agrees with patient Patrick Crommet that the experience of cancer can be "a gift." She applauds Dr. Scott "for his sensitivity and words of comfort. I guess that's why we're family physicians!"

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CORRECTIONS

In the second issue of the *Annals*, the editorial "Two Cheers for Ecology" by Dr. Kerr L. White (*Ann Fam Med* 2003;1:67-69) contained three errors. On page 67, the first sentence of the second paragraph should have read: "Fryer et al's study begins by illuminating the possibilities for enlightening health policy by means of the ecology model." On page 68, the paragraph that begins at the bottom of the first column should have said that the International Classification of Primary Care has been available for almost 2 decades, rather than 2 years. On page 69, the references cited in the last complete sentence in the first column should have been 16 and 17, not 17 and 18. Corrected full-text and PDF versions of this editorial have been posted on the *Annals* Web site. The current online versions therefore depart from the version published in the print version of the journal.

In the article by Kevin Fiscella et al, "Do HMOs Affect Educational Disparities in Health Care" (*Ann Fam Med* 2003;1:90-96), Minnesota was inadvertently attached to the University of Rochester in the credit line for Dr. Fiscella. The correct state is New York.

The Publisher regrets the errors.