4. Build Foundations for Community Involvement and Support

In addition to establishing trust with individuals, be it the participant or a health care clinician who is helping with recruitment, the broader issue of trust within the community also should be considered. If the community distrusts research, investigators may not even get the opportunity to build trust on an individual basis. Therefore, linking with community leaders is vital, as they can help set a positive tone regarding research activities. This includes not only making initial contacts to explain the research studies, but also maintaining ongoing relationships. Establishing community advisory panels can be one method of ensuring community involvement. Additionally, a commonly expressed frustration from community leaders is that once the study is finished, they are never informed what was learned. Thus, investigators should not believe their study is finished until they have disseminated their results back to the community and participants involved.

Although recruitment of minorities into studies may take active planning and implementation of extra measures, the wealth of information that will be available if minority recruitment improves are worth it. Ongoing studies are needed to continue to develop new strategies to improve recruitment overall, and specifically for minority participants.

Vanessa Diaz, MD

References

1. Branson RD, Davis K, Butler KL. African Americans' participation in clinical research: importance, barriers, and solutions. *Am J Surg.* 2007;193(1):32-39.
2. US Food and Drug Administration. 2005 Guidance for Industry: Collection of Race and Ethnicity Data in Clinical Trials. http://www.fda.gov/RegulatoryInformation/Guidances/ucm126340.htm.
3. NIH Policy and Guidelines on The Inclusion of Women and Minorities as Subjects in Clinical Research – Amended, October, 2001. Bethesda, MD: National Institutes of Health. http://grants.nih.gov/grants/funding/women_min/guidelines_amended_10_2001.htm.
4. Albrect TL, Eggly SS, Gleason MEJ, et al. Influence of clinical communication on patients' decision making on participation in clinical trials. *J Clin Oncology.* 2008; 26(16):2666-2673.

AAFP From the American Academy of Family Physicians

Ann Fam Med 2012;10:373-374. doi:10.1370/afm.1427.

AAFP PARTICIPATES IN CAMPAIGN TO CUT UNNECESSARY MEDICAL INTERVENTIONS

As part of an effort to help physicians curtail the practice of ordering unnecessary tests and procedures, the AAFP has released a list of 5 tests and treatments physicians should think twice about before performing, ordering, or prescribing. The list is part of a national campaign called Choosing Wisely that launched at a press event in Washington in April 2012. The campaign is working to identify specific tests or procedures commonly used yet not always necessary within various specialties.

The Academy's involvement in the Choosing Wisely campaign underscores family physicians' long-term commitment to ensuring high-quality, cost-effective care to patients, said AAFP President Glen Stream, MD, MBI, of Spokane, Washington, in a prepared statement.

"Family medicine's 'top 5' list encourages more in-depth conversations between patients and their doctors so they discuss all options and then 'choose wisely' when it comes to a treatment plan," he said.

According to the Congressional Budget Office, as much as 30% of care provided in the United States consists of unnecessary tests, procedures, medical appointments, hospital stays, and other services that may not improve people's health. CMS projects that if US health care spending continues at current levels, it will reach $4.3 trillion, or 19.3% of the nation's gross domestic product, by 2019.

In response, the Academy and 8 other medical specialty societies—the American Academy of Allergy, Asthma and Immunology; the American College of Cardiology; the American College of Physicians; the American College of Radiology; the American Gastroenterological Association; the American Society of Clinical Oncology; the American Society of Nephrology; and the American Society of Nuclear Cardiology—joined the Choosing Wisely campaign, which originated as an initiative of the American Board of Internal Medicine Foundation, last year.

The 9 organizations initially participating in the Choosing Wisely campaign worked individually and collaboratively to create evidence-based lists of overused tests and treatments for their individual specialties. Dubbed "Five Things Physicians and Patients Should Question," the lists are designed to help physi-

cians and patients think and talk about overuse or misuse of health care resources.

The AAFP's list consists of the following 5 recommendations:

1. Do not do imaging for low back pain within the first 6 weeks, unless red flags are present. Red flags include, but are not limited to, severe or progressive neurological deficits or when serious underlying conditions such as osteomyelitis are suspected. Imaging of the lower spine before 6 weeks does not improve outcomes, but does increase costs and involves unnecessary radiation exposure. Low back pain is the 5th most common reason for all physician visits.
2. Do not routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for 7 or more days or symptoms worsen after initial clinical improvement. Symptoms must include discolored nasal secretions and facial or dental tenderness when pressure is applied. Most sinusitis in the ambulatory setting is due to a viral infection that will resolve on its own. Despite consistent recommendations to the contrary, antibiotics are prescribed in more than 80% of outpatient visits for acute sinusitis, resulting in risk of side effects without benefit. Sinusitis accounts for 16 million office visits and $5.8 billion in annual health care costs.
3. Do not use dual-emission X-ray absorptiometry (DEXA) in women aged younger than 65 years or men aged younger than 70 years with no risk factors. DEXA is not cost-effective in younger, low-risk patients but is cost-effective in older patients.
4. Do not order electrocardiograms or other cardiac screening for low-risk patients without symptoms. There is little evidence that detection of coronary artery stenosis in asymptomatic patients at low risk for coronary heart disease improves health outcomes. False-positive tests are likely to lead to harm through unnecessary invasive procedures, overtreatment, and misdiagnosis. Potential harms of this routine annual screening exceed the potential benefit.
5. Do not perform Pap smears on women aged younger than 21 years or who have had a hysterectomy for noncancer disease. Most observed abnormalities in adolescents regress spontaneously; therefore, Pap smears for this age-group can lead to unnecessary anxiety, additional testing, and cost. Pap smears are not helpful in women after hysterectomy (for noncancer disease), and there is little evidence for improved outcomes.

The lists drawn up by the campaign's 8 other medical specialty partners are available on the Choosing Wisely website. In addition, 8 more medical specialty organizations signed on to the campaign during the April 2012 press event. They are scheduled to release their lists this fall.

In an interview after the press event, Stream stressed the need to develop a solid, secure, physician-patient relationship so meaningful patient conversations can take place.

"People really do need a doctor who knows them and can help them navigate the medical system if they have a serious medical problem," he said. "It is also important to note that it is one thing to get a 'Choosing Wisely' decision from a doctor who knows you, but that to do that, you have to build trust up over time.

"I think that as family physicians, our role is unique, because we are not only managing the care that we give, but it is also just as critical that we coordinate care for our patients using our subspecialty colleagues."

Matt Brown
AAFP News Now

From the American Board of Family Medicine

Ann Fam Med 2012;10:374-375. doi:10.1370/afm.1423.

ABFM'S HEART FAILURE SELF-ASSESSMENT MODULE SIMULATION ACTIONS VIS-À-VIS GUIDELINE RECOMMENDATIONS

The American Board of Family Medicine (ABFM) introduced Maintenance of Certification for Family Physicians (MC-FP) in 2004 in response to policy adopted by the American Board of Medical Specialties (ABMS.)[1] ABFM reported in 2006 the initial Diplomate experiences with MC-FP.[2] At that time, ABFM had Self-Assessment Modules (SAMs), consisting of a 60-item knowledge assessment followed by a virtual patient clinical simulation available only for hypertension, type 2 diabetes mellitus, asthma, and depression. Since that time, ABFM has deployed modules for coronary artery disease, chronic heart failure, well child care, maternity care, preventive care, care of the vulnerable elderly, pain management, early childhood illness, cerebrovascular disease, and health behavior. Each of the SAMs includes a Diplomate assessment of both the knowledge assessment and the simulation components.

In addition to the Diplomates' subjective assessments of the SAMs, ABFM captures the actions taken during each simulation, including the action itself, the simulated date and time of the action, and the simulated patient's current health state. This information is