EDITORIAL

In This Issue: Policy and Practice

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This issue presents a wide variety of topics, from policy to practice, from mental health to multimorbidity, from the early years of life to the final year.

A pair of Point-Counterpoint articles argue the question: is a strategy focused on super-utilizers equal to the task of health care system transformation?[1,2]

A pair of systematic reviews and an accompanying editorial[3] provide a wealth of information on the effectiveness of different pharmacological treatments[4] and different psychological treatments[5] for patients with depression seen in primary care.

The study featured in this issue's *Annals* Journal Club examines the diagnostic usefulness of different combinations of lung function measures and finds that the combination of a fixed ratio of FEV_1/FVC or lower limit of normal cut-offs, plus a low FEV_1, is more strongly associated with clinical outcomes than other measures.[6] Another clinical study finds that the combination of laryngeal height measurement and a lung function questionnaire is useful for screening for COPD.[7]

In a prospective case series, ultrasound imaging appears to be useful in diagnosing acute shoulder pain and potentially for providing tailored treatment for people seen in family practice.[8]

A health care policy study shows a substantial decline in the percent of uninsured patients seen in community health centers since the Medicaid expansion supported by the Affordable Care Act.[9]

A careful examination of the resources needed to maintain viable health information technology identifies deficiencies in community health centers and rural practices.[10]

Across 6 European countries, a large study compares the rate of identification of patients with alcohol dependence by general practitioners versus a structured interview.[11] Interestingly, these 2 methods discover about the same number of alcohol dependent people, but there is little overlap between the people identified.

An important study by Gill and colleagues discovers 5 different clinical trajectories of disability for people in the year before hospice.[12] The findings have implications for better meeting the palliative care needs of people in the year before death.

A clinical practice guideline summary from the American Academy of Family Physicians offers evidence-based recommendations and guidelines for good clinical practice for labor and planned vaginal birth after a prior Cesarean delivery.[13]

An essay identifies potential impending shifts in both physician-directed and direct-to-consumer advertising due to new federal "Sunshine" regulations that require disclosure of certain marketing and industry payments to physicians.[14]

This issue contains a disquieting study that delineates the limited availability of physicians in rural areas who can prescribe buprenorphine for opioid use disorder.[15] The study addresses issues of rural health care delivery, opioid addiction, and creating a rational and effective health care workforce, that have been addressed with rigor and perspective over many years by the lead author, Roger Rosenblatt.

We were deeply saddened to learn of Dr Rosenblatt's death on December 12, 2014. Roger was a major contributor of relevant new knowledge and insights, and a leader in rural health care, since shortly after the rebirth of family medicine in the United States more than 4 decades ago. He trained several generations of family medicine leaders and investigators. Recently he expanded his broad vision to work on preserving intact ecosystems, open space, and wildlife habitat, gaining a forestry degree, educating children and adults, and preserving a forest in the process. We will miss, but continue to be sustained by, his warmth and wisdom.

We welcome your reflections at http://www.AnnFamMed.org.

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EDITORIAL

Treatment of Depression in Primary Care

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In the world of primary care, we have been struggling for years to render adequate care to our depressed patients. We often fail, even though we know that depression is common, painful, disabling, and expensive.[1] We also know that there are adequate treatments available. Or are there? For over 2 decades investigators have been testing whether that's true, and by now the number of studies runs into the thousands. So this is a good time to pause and take stock. What do we know about the 2 fundamental modalities—pharmacotherapy and psychotherapy—for treating depression in primary care? In this issue of the *Annals*, Linde et al present a pair of excellent meta-analyses that summarize and extend our current state of knowledge about the efficacy or effectiveness of these 2 categories of treatment for depression in the primary care setting.[2,3] These results, and the studies on which they are based, can help us understand something about how to care for these patients, the persistent shortfalls in our care, and what we might do next about those shortfalls.

The studies that form the substrate for these 2 meta-analyses are themselves revealing. The analysis of pharmacological treatments includes 66 acceptable studies with 15,161 adult patients.[2] These are the best of the randomized controlled trials comparing drugs of different classes to each other or to placebo. One-half of these studies have a high probability of bias of some sort, and another one-third are of uncertain bias status. In most of these studies the dosages are low, even below recommended dosages, and most are short-term trials of 24 weeks or less. Such is the state of pharmacotherapy trials in primary care: you could say this is a weak and messy set of studies. This collection of trials is not sufficient in number or quality to support many of the comparisons we might wish to make or to tell us with confidence which drugs are better for what, and how

Conflicts of interest: author reports none.

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