EDITORIAL

In This Issue: Refining Care and its Frameworks

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This issue's articles reveal options for improving care directly, or by reframing the physical and cognitive platforms from which it is practiced.

Behavioral activation with mindfulness training in a group intervention is found to be effective in reducing the incidence of major depressive disorder. The study by Wong et al is a clinical trial of primary care patients with subthreshold depression.[1]

In a clinical trial of US family medicine and pediatric practices, Yawn et al find that the Asthma APGAR tools improve asthma control and adherence to asthma management guidelines, and reduce asthma-related emergency department, urgent care, and hospital visits.[2] The Asthma APGAR tools cue clinicians toward comprehensive asthma management by linking a control score based on a patient survey with a care algorithm.[3,4]

The 5-year experience of an electronic consultation service involving 14,105 eConsult cases with 56 different medical specialty types is evaluated by Liddy and colleagues.[5] With an average response time of 21 hours and with nearly two-thirds of eConsults resolved without a specialist visit, use of the system rose rapidly over a 5-year period. The implications for efficient and patient-responsive care seem profound.

Two studies provide context for understanding and improving the effects of multimorbidity:

Mercer and colleagues examine the effects of multimorbidity on general practice consultations in areas of high and low deprivation. In 659 video-recorded consultations with 25 general practitioners, they find that consultations with patients with multimorbid conditions are longer in affluent areas, but not in deprived areas. In affluent areas, multimorbid patients perceive their doctor as more empathetic compared to other patients, and observations reveal that the doctors are more attentive to the disease and illness experiences of multimorbid patients.[6]

Due to the need for more research on people living with multimorbidity, Smith et al use a Delphi process based on a systematic review and prior workshops to identify 17 outcomes that are useful for different purposes in studying multimorbidity.[7] The identification of multiple potentially important outcomes of multimorbidity provides a useful starting point for investigators trying to improve understanding and outcomes for people living with multiple chronic conditions.

Two studies shine light on different questions regarding prostate cancer screening:

Fedewa et al examine prostate-specific antigen (PSA) testing in light of recommendations for shared decision making and balanced presentation of information. They find that during the past 5 years, there has been a shift away from patients being told only about the advantages of PSA testing toward fuller shared decision discussions, despite no overall increase in rates of shared decision making.[8]

Profetto et al examine a different test for screening for prostate cancer—digital rectal examination. In a systematic review and meta-analysis, they discover that rectal exam has low sensitivity, specificity, and positive and negative predictive value for finding biopsy-proven prostate cancer. Overall, the quality of evidence for use of rectal exam as a screening test is low.[9]

Since prior studies have found an association with neuropsychiatric events, including suicide, among children given oseltamivir to treat or prevent influenza A or B, Antoon and colleagues use a case-crossover study to examine this concern. They find no association between oseltamivir, or an influenza diagnosis, and suicide.[10]

Moving from problem-oriented to goal-directed care could make a large difference in the effectiveness and patient-centeredness of health care.[11,12] In a special report in this issue, Nagykaldi et al propose electronic medical record design principles to support care that is anchored in the patient's life and health goals.[13] Electronic health records based on these principles would be very different from what we now are using and might allow medical records to better support goal-oriented care.

The *Annals* feature on Innovations in Primary Care includes a novel approach to applying citizen engagement methods in primary care to gather recommendations from a representative group of patient advisors, and using them to prioritize areas for improvement in the practice.[14] Another advance involves an effort to increase practice effectiveness and efficiency through a team approach to ordering laboratory tests.[15]

Four essays enlighten life transitions:

Egnew envisions that by helping patients to construct their illness stories, healers can help people dealing with chronic and terminal illness to transcend the suffering provoked by the degradations of their illness.[16]

Finklestein uses lived experience and an anthropologist's eye to reflect on the new life promised and pursued after a total colectomy for ulcerative colitis.[17]

Reuben explicates what might happen if the balance of physicians' responsibilities shift from transactional tasks toward personalized care.[18]

Loxterkamp presents a deeply personal yet universal reflection on the unrest and prospects of stepping back from a full life as a family physician into the as yet uncertain possibilities of retirement.[19] I encourage multi-generational groups to use this article as a basis for personal and shared contemplation about loosening current attachments and being open to new possibilities. Please share the results of these reflections and discussions in the TRACK comments related to this essay.

We welcome you to join the online discussion for each of the articles at http://www.AnnFamMed.org.

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