ON TRACK

Improving Health Care Locally and Globally

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More than 100 online comments have been posted since our last On TRACK summary. *Annals* readers are insightful and are sharing those insights! Much of the discussion relates to the supplement based on the World Organization of Family Doctors (Wonca) international conference on family medicine research[1] and to continued discussion of the Future of Family Medicine Project report.[2] In addition, original research articles continue to generate valuable debate and comment. Below I highlight a few threads from these discussions.

IMPROVING HEALTH GLOBALLY AND THE NEED FOR PRIMARY CARE RESEARCH

Among a multitude of thoughtful comments from diverse perspectives across the world, Lee Gan Goh from Singapore summarizes, "The Kingston recommendations together form a road map for organizational, national and regional efforts at developing family medicine research infrastructure and processes."[3] Dr. Goh groups the recommendations into 3 categories: (1) building dissemination mechanisms and a clearinghouse, (2) building research infrastructure and processes, and (3) building social capital. Dr. Rosser, one of the supplement editors and conference organizers, comments on his new understanding of the commonalities in the needs and recommendations for so-called developed and developing countries.[4] He also highlights the potential benefits of two-way mentorship between individuals, institutions, and developed and developing countries. A number of discussants look forward to future Wonca meetings as opportunities to build on this road map for developing family medicine research internationally. We invite readers to continue to use the online TRACK discussion to develop ideas and action plans to pursue at these meetings and in other diverse locales.

APPLICATION AND CRITIQUE OF CLINICAL RESEARCH

The study of the predictive value of a single set of vital signs by Tierney et al[5] is generating an enlightening back-and-forth discussion between readers and the author. This discussion (which can be found by clicking on the Published Track Comments in the upper-right corner of the full-text article at http://www.annfammed.org/cgi/content/full/2/3/209) shows how these findings can and should change our practice by making us more likely to act on single abnormal readings.

A new technology reported by Gill et al in the last *Annals*[6] showed the possibility that a new ophthalmoscope could be used for primary care patients at high risk for not being screened. The ensuing TRACK discussion presents a strong rationale from readers[7,8] and the author[9] for selectively using a nonmydriatic scope to screen for retinopathy in diabetic patients who do not or cannot have examinations by an ophthalmologist. A physician who participated in the study vouched for the feasibility of being trained to use the panoptic ophthalmoscope but concluded that an inadequate reimbursement system makes this potentially feasible additional service infeasible.[10] Interestingly, this discussion of a specific new technology exemplifies an element of the Future of Family Medicine discussion (see below). Both discussions espouse new technologies to improve care of patients in the primary care setting, but both note that a dysfunctional reimbursement system thwarts the ability of family physicians to provide their patients with beneficial care.

Reflecting on research by Bertakis et al,[11] the executive director of the American Chronic Pain Association reminds us of the need to provide pain treatment early in the illness course and to consider pain in the context of the individual's quality of life.[12]

Original research by Zink et al[13] provided evidence for a stage-based framework to create a safe environment in which women can disclose and be supported in dealing with intimate partner abuse. The discussion to date highlights the need to create that safe environment[14] and the importance of considering relapse in identifying patients' stage.[15] A clinician notes the immediate effect of this study on her own work,[16] while a librarian at the National Center on Domestic and Sexual Violence calls for doctors to use their common sense and other knowledge, as well as these new find-

ings.[17] Goodyear-Smith, citing her own in-press work,[18] calls for the use of a generic question about violence and threats as a more widely applicable and potentially more acceptable way of screening.

The study showing high rates of misunderstanding among patients buying a nonprescription bladder anesthetic[19] was cited by Ganiats as an example of the importance of moving research into the community, and as an exemplar of multidisciplinary investigation.[20]

The systematic review on treatment of carpal tunnel syndrome[21] provided a forum for a researcher using laser acupuncture to cite her data on effectiveness.[22]

CONTINUED DISCUSSION OF RESEARCH FROM PREVIOUS ISSUES

The editorial by Williams in the March/April issue of the *Annals*[23] continues to provoke impassioned testimony from those with firsthand experience of community-oriented primary care (COPC).[24-26] For these proponents, lack of appreciation and financing are barriers to implementation of a model that integrates personal medicine with community and public health. Nighswander raises similar themes in discussing the supplement on the Wonca conference and calls for action by Wonca to implement and evaluate the COPC model.[27]

An in-depth response[28] by the authors of the natural history study of asthma[29] highlights how differences in measurement and sample can lead to different conclusions about the predictive utility of bronchial hyperresponsiveness testing.[30]

The topic of intimate partner abuse continues to resonate with discussion of the recommendation statement "Screening for Family and Intimate Partner Violence" by the US Preventive Services Task Force.[31] Discussants call for the production of further evidence at the levels of the clinical encounter and the health system,[32,33] as well as for action even in the absence of such evidence.[34]

We wish to call particular attention to the detailed May 19 response of Schillaci and Waitzkin[35] to concerns raised about their mixed methods study of the effects of declining immunization coverage in New Mexico.[36] They present new and expanded analyses and additional interpretation to support their original conclusion of declining immunization coincident with Medicaid managed care.

FUTURE OF FAMILY MEDICINE

The degree of thought and passion in the discussion of the Future of Family Medicine report remains high. A "Modest Proposal" by Heck,[37] "Critical Issues" by McDaniel,[38] and "Taking Steps" by Goh[39] give us bigpicture frameworks for considering how to move forward. Comments from the front lines by Delgado,[40] Sanazaro and Lake,[41] Elliott,[42] Egerton,[43] McGlauglin,[44] and others remind us of the tremendous challenges and disappointment with the environment for practice, our organizations, and the report. These comments speak to the limited "slack" in the current environment, that is, the constrained space that many feel for innovation and proactive adaptation. We look forward to the report of the final Future of Family Medicine task force, which will offer analyses of alternative financial models. We also invite readers to share "new models" or adaptations of old models that they have found useful in their communities and practice environments.

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CORRECTION

The author list for the report of Task Force 1 of the Future of Family Medicine project has been corrected in the report, which appears online at http://www.annfammed.org/cgi/content/full/2/suppl_1/s33. A singularly unfortunate error had led to the omission of the names of the first author, Larry A. Green, MD, and the corresponding author, John Swanson,MPH. We are glad to be able to correct the omissions.