ON TRACK

Questions, Interpretation, Exhortation

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The very thoughtful online discussion since the last issue represents 3 themes: questions, interpretation, and exhortation.

QUESTIONS AND ANSWERS

Dietrich commends Roetzheim and colleagues[1] for sharing the specific tools that made their cancer-screening intervention successful in community health centers. Dietrich asks whether downloads of these tools, which were provided in an *Annals* online appendix, are being tracked, and whether others have experience in disseminating intervention materials in this way.[2] We can report that, during the first 4 weeks after these materials were published, the online appendix was accessed more than 100 times. We do not know who downloaded the materials or how they were used. If you have a story about using or providing intervention materials online, please share it in a TRACK comment at http://www.annfammed.org.

The RESPECT-Depression (Re-Engineering Systems for Primary Care Treatment of Depression) study[3] brought both praise and questions about the transportability of the model. "(I)s this a program that the average practice can, and does, implement?"[4] "Are there opportunities for even more economies of scale" by expanding the RESPECT model to include chronic illness care?[5] "Is anyone aware of a CPT code that allows billing for depression telephone support or for other chronic illnesses? Are any health plans reimbursing for such calls?"[6]

The study on subclinical hypothyroidism and the risk of hypercholesterolemia[7] raised questions about the place of this study in the existing literature[8] and the interpretation of the meaning of mildly elevated TSH levels.[9] The response by Hueston and colleagues[10] emphasizes the uniquely population-based nature of the study sample and calls for a cautious interpretation of the benefits of treatment in studies done with more selected samples.

INTERPRETATION

Most of the online discussion interprets the studies, essays, or editorials and puts the published papers into the context of personal experience or what is already known from previous studies and publications. The personal experience that enriches the discussion can be from a variety of perspectives, including the clinician, patient, researcher-author, administrator, or leader. Discussion of what is already known brings insights from previous studies, publications, and personal or collective experience. This interpretation takes the form of challenge, hypothesis, and nuance.

In the recent TRACK discussion, the "on the ground" perspective was provided by 1 of the 5 site principal investigators of the RESPECT-Depression study.[11] Korsen shares the following lessons for "what I believe is a permanent transformation in the way people with depression are cared for in primary care practices in our system." These lessons are to engage leaders at all levels, engage a variety of staff, take advantage of emergent change, help practices link measurement to their improvement efforts, expect competing demands, and understand the need for reinvention. Pincus[12] puts the contribution of this study into the context of what is already known and calls for next steps that address financing and sustainability of integrating depression care more fully into the management of chronic conditions.

The model for clinician self-awareness proposed by Borrell-Carrió and Epstein[13] was interpreted as "reminding us that the individual physician is a subsystem in context." This interpretation helps to overcome the false dichotomy between system and relationship approaches decried by Scherger[14] and is consistent with Granat's understanding that errors can be reduced through approaches that focus on the "small and personal."[15]

The qualitative study[16] of "the more than 200 stories we heard"[17] generated reflections from a patient rights activist. She asserts the centrality of trust and confidence in the patient's relationship with the primary care physician and notes how this relationship, as well as the opportunity to assist with healing, is often destroyed by how the doctor responds to a patient's injury.

The study on the appropriateness of Lyme disease serologic testing[18] raised challenges from a clinical and research expert on Lyme disease[19] and from a patient

and advocate who has suffered from delayed diagnosis.[20] They question the study's definition of Lyme disease symptomatology and the benign categorization of the disease, and they call for appropriate testing.

The study of patient wishes regarding discussion of spirituality[21] elicited an unusually rich and diverse discussion from the perspectives of clinicians, researchers, chaplains, and educators. These thoughtful comments raise the importance of context and relationships[22] and patients' "desire for compassion, understanding and hope."[23] The need for appropriate training and follow-up of identified spiritual issues and patients' needs for holistic health care was addressed by 4 discussants[24-28] and by the authors' response.[29] Another careful reader interprets the findings as indicating "that patients do not want physicians in a highly interpretive role."[30]

The US Preventive Services Task Force recommendation on syphilis screening[31] highlights the challenges of screening strategies that are based on identification of risk factors.[32-35]

The author of the essay entitled "Pounds"[36] summarizes the appreciative comments and personal reflections of the discussants[37-39] as pointing "to the importance of 'context' when making clinical decisions. In my view, it takes a long time—longer than a residency certainly—to get really comfortable with this notion." He points out that figuring "out what medical decision best fits the patient's values system … does not always match the guidelines."[40]

A clinician shares his experience that with good training it is often possible to "visualize the retina up to 3 or 4 disc diameters from the center of the optic disc,"[41] even without the newer PanOptic scope studied by Gill and colleagues.[42]

Another clinician raises the hypothesis, based on her experience, that pain scales are less useful and specific in the primary care setting than in the settings in which they typically are developed.[43]

Patient responses[44-46] to the US Preventive Services Task Force recommendation against routine ovarian cancer screening[47] show how the perspective of a person with the disease may differ from those considering screening, or in this case, from those evaluating the scientific evidence for screening asymptomatic persons.

Harkening back to the theme of the *Annals* first issue, the program director of the Office of Cancer Survivorship at the National Cancer Institute identifies the critical role of comorbid conditions on posttreatment follow-up care of childhood cancer survivors.[48]

EXHORTATION

A number of articles, including some mentioned above, led to calls for action. The articles on patient safety generated calls for "studies of relationship centered care placed in the context of modern care tools and methods,"[14] and for reducing errors through approaches that focus on the "small and personal."[15]

Fisher[49] and Aikens[50] urge addressing the practical problems that impede the implementation of integrated approaches to care, such as the PRISM-E intervention. Baird further exhorts: "the time has come for integrating mental health services directly into primary care practices.… Eventually, we may come to the realization that people arrive in primary care offices with their mental health dilemmas as interwoven issues not always rationally separated from their medical problems. Appropriate evaluation and treatment should reflect the same natural integration." [51]

A psychologist in a family medicine residency program reacts to the study of patient's desires for spiritual discussion[21] with a call to change the focus of our screening for depression. Screen for "joy … passion … or meaning and purpose."[24] The same article elicited a call for "questions to better understand patients and their wholeness, and through this dialogue offer compassion and hope."[52]

A participant in the Wonca family medicine research conference, which was the topic of a May/June 2004 *Annals* supplement,[53] highlights the call for a participatory research approach characterized by 3 features: "collaboration throughout the research process, mutual education, and action on the results that are relevant to the community."[54]

The Future of Family Medicine report[55] continues to draw calls for "addressing the fundamental identity problem"[56] and valuing the frontline perspective.[57] Another discussant says, "We should not stop fighting for what is right, but we should quit whining."[58]

Another call for a community and grassroots framework[59] argues for the feasibility of widespread training in, and use of, the community-oriented primary care model.

Join the discussion of articles at http://www.annfammed.org.

Editor's note: After this On TRACK was submitted, several authors posted thoughtful responses to discussants' comments.[60-62] These, and additional new comments by other readers, show the increasingly interactive and ongoing nature of the TRACK dialogue, and the benefits of periodically "checking in" for those who want to keep their fingers on the pulse of the vibrant community of those who are using and producing the new information shared through the *Annals*.

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CORRECTION

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The list of members of the U.S. Preventive Services Task Force (USPSTF) for the Agency for Healthcare Research and Quality (AHRQ) recommendation statement on screening for syphilis infection was out-of-date (U.S. Preventive Services Task Force. Screening for syphilis infection: recommendation statement. *Ann Fam Med.* 2004;4:362-365). The authors regret the error. Below is the correct list:

Members of the U.S. Preventive Services Task Force* are Alfred O. Berg, MD, MPH, Chair, USPSTF (Professor and Chair, Department of Family Medicine, University of Washington, Seattle, Wash); Janet D. Allan, PhD, RN, CS, Vice-chair, USPSTF (Dean, School of Nursing, University of Maryland, Baltimore, Baltimore, Md); Ned Calonge, MD, MPH (Acting Chief Medical Officer, Colorado Department of Public Health and Environment, Denver, Colo); Paul S. Frame, MD (Tri-County Family Medicine, Cohocton, NY, and Clinical Professor of Family Medicine, University of Rochester, Rochester, NY); Joxel Garcia, MD, MBA (Deputy Director, Pan American Health Organization, Washington, DC); Leon Gordis, MD, DrPH (Professor, Epidemiology Department, Johns Hopkins Bloomberg School of Public Health, Baltimore, Md); Russell Harris, MD, MPH (Associate Professor of Medicine, Sheps Center for Health Services Research, University of North Carolina School of Medicine, Chapel Hill, NC); Mark S. Johnson, MD, MPH (Professor of Family Medicine, University of Medicine and Dentistry of New Jersey-New Jersey Medical School, Newark, NJ); Jonathan D. Klein, MD, MPH (Associate Professor, Department of Pediatrics, University of Rochester School of Medicine, Rochester, NY); Carol Loveland-Cherry, PhD, RN (Executive Associate Dean, School of Nursing, University of Michigan, Ann Arbor, Mich); Virginia A. Moyer, MD, MPH (Professor, Department of Pediatrics, University of Texas at Houston, Houston, Tex); Judith K. Ockene, PhD (Professor of Medicine and Chief of Division of Preventive and Behavioral Medicine, University of Massachusetts Medical School, Worcester, Mass); C. Tracy Orleans, PhD (Senior Scientist, The Robert Wood Johnson Foundation, Princeton, NJ); Albert L. Siu, MD, MSPH (Professor and Chairman, Brookdale Department of Geriatrics and Adult Development, Mount Sinai Medical Center, New York, NY); Steven M. Teutsch, MD, MPH (Executive Director, Outcomes Research and Management, Merck & Company, Inc., West Point, Pa); and Carolyn Westhoff, MD, MSc (Professor of Obstetrics and Gynecology and Professor of Public Health, Columbia University, New York, NY).

*Members of the Task Force at the time this recommendation was finalized. For a list of current Task Force members, go to www.ahrq.gov/clinic/uspstfab.htm.