

Commentary on the CRISP Statement

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Ann Fam Med 2023;21:482. <https://doi.org/10.1370/afm.3066>

This issue of *Annals* presents an important article proposing guidelines for the reporting of primary care research.¹ Written by a team of international family medicine researchers and editors representing 3 continents, the “Consensus Reporting Items for Studies in Primary Care” (CRISP Statement) reflects years of collaborative work. The authors used sound methodology to craft a list of 24 items, which were discussed, debated, and tested with multiple international audiences.

As family medicine researchers and scholars, we applaud the authors' work and seek to further the impact of the CRISP statement. While not specifically stated in the guidelines, we encourage researchers to collect and report race/ethnicity and gender when describing patients. Family medicine research was instrumental in identifying racial, ethnic, and gender health inequities in the United States. Reporting these differences remains important as we continue to seek health equity over time. We are aware that outside of the United States, legal restrictions may delimit the collection of patient race/ethnicity without informed consent, or may incorporate stringent privacy safeguards, but it is our opinion that where these patient characteristics are systematically collected, they should be reported.

We were delighted to read the guidelines suggesting that authors report whether and how patients were involved in a research project. Family medicine research is patient-focused, and generally seeks solutions to problems that patients care about. Yet, in many studies, patients are no more than research subjects. Patients matter in our field; our research reports can and should reflect the involvement of these research participants. It is our hope that as these guidelines become widely implemented, more patients' voices will be sought out and included in primary care research processes and reports.

Conflicts of interest: authors report none.

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The checklists that the authors provide under the category, “Discuss the meaning of study findings/results in the context of primary care” can further enrich the adaptation of research findings to different contexts. The checklists can enhance both the design and reporting of research. The items about implementation are unique to the CRISP guidelines and could increase the importance of communicating the relevance of studies for primary care practice and policy.

Although guidelines alone do not change research, practice, or policy, nor are they often rapidly implemented, even the publication of the CRISP guidelines offers an opportunity for change. Because the CRISP guidelines may be more useful than existing guides to reflect the unique aspects of primary care, following them offers the potential to more rapidly elevate family medicine research. The proposed CRISP guidelines can interdigitate well with existing guidelines; for example, CONSORT is already required by most major biomedical journals, making the adaptation of the CRISP guidelines less arduous. The major strengths of the proposed CRISP guidelines, beyond further endorsing primary care research as separate and unique, are their focus on implementation. The guidelines provide a tool for change, by capturing users' comments in real time. The developers can enhance implementation as they continue to adapt the guidelines over time, using these comments alongside continued empirical study of CRISP use in different primary care contexts.

The authors were generous in their invitation for feedback; they want these guidelines to be a living document. Our readers can provide feedback at <https://crisp-pc.org>. We invite family medicine researchers to objectively examine the CRISP guidelines, implement them, and give feedback to the authors on what works and what does not. Working together, we can make these guidelines more meaningful for the growing community of family medicine researchers.

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Key words: primary care research; reporting guidelines; consensus; research impact
Submitted October 27, 2023; accepted October 27, 2023.

References

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