EDITORIAL

In This Issue: Bursting the Bubble on Chronic Disease Management, the Meaning of Healing, PBRN Methods Supplement, and the *Annals*' 2-Year Anniversary

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This issue features a provocative collection of articles that address different aspects of the integration of care of multiple comorbid illnesses in primary care.[1-5] Other articles reflect the patient perspective and the clinician perspective on health, illness, and healing. An online supplement advances the methods for practice-based network research.[6] In a special online article, the editors analyze the current state and future opportunities for primary care research, looking through the lens of articles published in the first 2 volumes of the *Annals*.[7]

Chronic Disease Management, Comorbidity, and Collaborative Quality Improvement

In one of only a handful of controlled pre-post evaluations of a Breakthrough Series Collaborative, Schonlau and colleagues[1] find that this approach improves process measures for asthma care, but has no effect on patient outcomes. The accompanying editorial by Solberg[5] casts a skeptical eye on the evidence for the effectiveness of collaboratives. He points out the limitations, not only of the scientific literature on this increasingly popular quality improvement method, but also of its constrained application to single topics among highly selected participants. By identifying a typology of collaborative approaches, however, Solberg provides a starting point for the thoughtful implementation and rigorous evaluation that will be needed if the collaborative approach is to assume an important place among the panoply of practice transformation approaches.

The provocative analysis by Østbye and colleagues[2] finds that 3.5 hours per day is required for a family physician with a typical patient panel to care for 10 chronic diseases. Putting sufficient effort into helping patients with poorly controlled disease increases the time demand to more than 10 hours per day. A similar analysis by the same group[8] showed that 7.4 hours per day is needed to provide evidence-supported preventive care. The potential unfeasibility of implementing guidelines to improve the process of care, coupled with Schonlau's findings[1] that altering the process of care doesn't necessarily affect patient outcomes, are a cause for humility in our approach to quality improvement. We need to reflect on tradeoffs, professionalism,[9] and the undervalued opportunities inherent in integrating and personalizing care.[10,11]

Studies by Starfield et al[12] and Fortin[4] bring the additional perspective of multimorbidity into consideration. If care of individual chronic illnesses is difficult, what about the majority of patients with more than 1 chronic illness? It turns out that in family practice patients, having more than 1 condition is the rule rather than the exception, even among young adults.[4] It is not at all clear that the association of higher comorbidity with greater use of specialist physicians found by Starfield and colleagues[10] is the appropriate response to caring for patients with more illnesses. Developing systems to integrate care for multiple acute and chronic illnesses, along with providing preventive, mental health and family care, may be the optimal solution.[10] This hypothesis is plausible, but the reductionist paradigm that currently guides much of research, quality improvement, and care organization is blind to its possibilities. A more comprehensive vision and integra-

tive approach to health care research, financing, and delivery is needed to evaluate the possibilities inherent in an integrative approach that supports and emphasizes full-scale primary care.[12]

Perspectives of Patients and Physicians

A jewel of an article by Egnew analyzes interviews with Drs Eric Cassell, Carl Hammerschlag, Thomas Inui, Elisabeth Kubler-Ross, Cicely Saunders, Bernard Siegel, and Gayle Stephens about their definition of healing.[13] The rich results coalesce around the highly personal themes of wholeness, narrative, and spirituality, resulting in a definition of healing as the personal experience of the transcendence of suffering.

The study by Taylor and Taguchi[14] provides interesting insights into the translation of findings from the Breast Cancer Prevention Trial into practice. This trial showed the effectiveness of tamoxifen in reducing the incidence of breast cancer among high-risk women. Even so, these researchers find that only 1 of 89 high-risk women informed of this evidence chose to take tamoxifen, and among the 48 who discussed the option with their family physician, only 3 family physicians recommended preventive tamoxifen use. The values that patients and their clinicians place on risk and side effects are important considerations in applying evidence in practice and may account for low rates of translation of research from clinical trials into less selected patient populations and clinical settings.

Patients tell clinicians how they want us to approach interventions for family violence in a qualitative study by Burge and colleagues.[15] Women and men want us to ask about family conflict, listen to their stories, and provide information and referral.

An essay by Flake explores generational differences among physicians in use of scientific evidence rather than experiential evidence as the foundation for clinical decisions.[16]

Health Services Research With Clinical and Policy Application

The relationship between physicians' interpersonal style and patient outcomes appears to have been well established in previous research. Franks and colleagues[17] find, however, that this association disappears when more sophisticated multilevel modeling techniques are used. The findings affirm the need to use multilevel techniques when analyzing nested data[18] and call for sophisticated studies to identify styles of patient-clinician interaction that matter for health outcomes.

In an analysis of Latina immigrants, US-born Latinas, and non-Latina white women, Rodriguez and colleagues find evidence for the important effects of acculturation, socioeconomic factors, and health insurance in eliminating disparities in rates of breast and cervical cancer screening.[19]

An essay by Phillips and colleagues[20] analyzes the recent Council on Graduate Medical Education (COGME) physician workforce report. Their analysis calls into question the need to expand the physician workforce and identifies the possibility of important unintended adverse consequences.

In an updated Recommendation and Rationale,[21] the US Preventive Services Task Force recommends screening high-risk women for gonorrhea infection but finds insufficient evidence to recommend for or against screening for men. The Task Force finds that harms outweigh benefit of screening low-risk men and women but finds strong evidence to support neonatal ocular prophylactic medication.

Supplement on Practice-Based Network Research Methods

We are pleased to publish a supplement to this issue of the *Annals* that should be of great interest to our many colleagues engaged in developing new knowledge for primary care through practice-based research networks. The supplement is entitled "Contemporary Challenges for Practice-Based Research Networks" and was sponsored by the Primary Care Center of the Agency for Healthcare Research and Quality (AHRQ). The supplement includes an article by Green et al discussing the infrastructure that a PBRN will need to maintain its network communications and conduct a range of research activities.[22] Pace and Staton describe the variety of strategies that may be used for electronic data collection, transfer, and management, and they underscore the importance of matching the technology to the specific requirements of the project.[23] van Weel reviews the importance of data collected for extended periods to primary care research and offers suggestions for accomplishing longitudinal data collection.[24] Wolf et al and Pace et al shine much needed light into the difficult issues faced by PBRNs in complying with requirements for protection of human subjects through IRBs[25] and protection of sensitive patient data through HIPAA regulations.[26] Dickinson and Basu collaborate on an important article that emphasizes the need to consider the hierarchical (nested) characteristics of data, and illustrates the implications of failing to do so with a mock dataset.[27] Finally, Mold and Peterson consider the potential overlap between research and quality improvement and urge us to recognize the important opportunities that PBRNs have to evolve into collaborative learning communities.[28] Together, these articles provide ideas and tools for furthering the development of the practice-based research networks that are a crucial engine for primary care research.

To read or post commentaries in response to this article, see it online at http://www.annfammed.org/cgi/content/full/3/3/194.

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