ON TRACK

Radical Ideas

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One function of the *Annals* online discussion (called TRACK) is to incubate and reveal emerging, sometimes radical ideas. Whereas the strength of the main body of articles published in the *Annals* is the peer-review process, the resulting selection process tends to emphasize the best of what is. The online discussion is more raw and emergent—a forum for what might be. The synopsis of the discussion presented here (called On TRACK) draws attention to a vision, emerging from the many venues of *Annals* readers' lived experience, of how primary care can be transformed to meet the growing needs for chronic care and how true healing processes can be fostered. This On TRACK synopsis also highlights other radical ideas, using a sample of quotations from the online discussion.

CHRONIC CARE AND THE MANAGEMENT OF MULTIMORBIDITY

Studies by Starfield, Østbye, and Fortin in the last issue of *Annals*[1-3] brought forth from readers creative ideas about a vitally important role for primary care to meet the growing unmet needs for integrated care of multiple conditions.

The current financial model in the United States is antithetical to the needs of the population for high-quality, accessible, integrated health care. A new financing model is need to develop the most important value of primary care—the ability to provide and integrate care within the context of relationships with the patient, family, community, and the rest of the health care team. Current payment models, which emphasize large panel sizes and force short visits focused on single diseases, impede rather than foster relationships. Financing needs to encourage, rather than penalize, increasing access to those most in need.[4-10]

The tautological assumptions of recent workforce projections[11] do not even begin to consider the possibility that reimbursement changes could expand primary care in ways that profoundly improve the health of the population.[12]

Forward-looking discussants highlight the need to use guidelines as only one part of a toolkit to support quality, rather than as a hammer that can pound out subtlety and personalization.[7,13]

The supplement on Contemporary Challenges for Practice-Based Research Networks[14] elicited apparently radical calls for supporting these learning laboratories—for developing the needed relationships among diverse participants and for sustainable electronic and personal infrastructure to develop the knowledge base for primary care.[15-20]

HEALING

The calls for system reform highlighted above also represent an appeal to develop systems in which a broader range of healing is facilitated. The study by Egnew[21] "draws our attention back to the original intent of being a doctor, where technical knowledge and medical interventions need to be used in service of the person of the patient."[22]

"A response to suffering and the ordeal that it causes patients may most call for healers to 'be present.' Being present is indeed the most challenging aspect of healing for the courage it requires.… Putting these ideas together implies that a physician healer would be willing to accompany a patient on a journey into vulnerability to confront the demons of loss, fear, grief, and isolation that cause suffering. This journey is neither cognitive nor procedural, but emotional and unpredictable. Such confrontation offers the patient the possibility of finding a new equilibrium, sense of integrity and wholeness invested with new meaning."[23]

"[T]he physician-patient relationship is important, but not necessarily central in the healing process. Family and community relationships may be even more important."[24]

"I wish I had remembered, when Tom Egnew interviewed me, to talk about the role of imagination in healing.… The physician's clinical imagination must be adequate to discover and respond to the sick patient's altered self-consciousness. Illness induces predictable and identifiable fears and fantasies in medical settings, among which are fear of strangers and separation

anxiety, fear of the loss of love and approval, of losing control of one's body and mind, of injury and mutilation, along with guilt and shame and fear of retaliation. These threats undermine and subvert the patient's sense of integrity and inhibit recovery. A physician who is unable or unwilling to deal with these demons is unlikely to rise above the requirements of mere technical competency. It is a formidable undertaking to wrestle with another's injured self-consciousness but that is the place where healing happens."[25]

OTHER RADICAL IDEAS

• "Treatment/caring in medicine today is seen as a commodity, with a measurable outcome that happens in a limited time and with a price tag on it. Can healing be a commodity?"[26]

• "Family medicine is not merely the sum of our checkmarks.... Do not use (guidelines) as checklists to measure quality. Rather, apply them with intuition and creativity to integrate the guidelines with other chronic disease considerations, one or two acute problems, family needs, work problems, ethnic preferences, chemical dependency, transportation and economic constraints, drug sensitivities, preferences for the 'pink pill' or the 'blue pill,' the insurance restrictions, prior authorization, information from consultants and lab reports.... Foster and enjoy the relationship with each patient."[13]

• "[T]he rapid screening for HIV simultaneously should be considered to be incorporated while screening for gonorrhea."[27]

• "The healthcare system has unnecessarily and unwisely limited its focus to post-event services for victims and punishment and isolation of perpetrators through the criminal justice system. As a clinician, I have experienced how health-system and community-level constraints have led to patterns of diagnosis, treatment, and health care delivery that do not address the root cause of intimate partner violence—perpetration."[28]

• "By the time most people have tried acupuncture they feel either that their doctor has given up, they can't deal with the medications, and/or they are trying every type of alternative treatment they have ever heard of. If you only knew how many times patients refer to their doctors as 'an idiot.'"[29]

• "If family physicians were valued and paid commensurate with their value, then their impressive income would be more than enough to lure medical students to the specialty."[30]

• Regarding practice-based research networks: "Who will step up?" to invest in sustaining funding to "stabilize these critical laboratories—so little for so much."[15]

• "[The *Annals*] is accountable to the field, to its readers, to its sponsors, and to those who are working to build the strength and authority of family physicians."[31]

• "Clinical Jazz is the harmonious relationship between our experience as clinicians, the personal needs and desires of individual patients, and the best evidence offered by staying up to date with medical information."[32]

• "Although I am not a Moslem, [I believe] in one of their sayings which means that the almighty helps those who take up the challenge."[33]

MOVING FORWARD

The discussion since the last issue reflects some of the most important questions in health and (primary) health care. I encourage you to read the original comments, and particularly suggest the commentary by Fiscella.[4] The perspectives of Aita,[23] Hroscikoski,[9] Bayliss,[10] and Agarwal[5] also contain radical ideas that are ripe for implementation. Please contribute your vitality to this discussion at http://www.AnnFamMed.org. Click on "Discussion of articles" or follow the links for the article on which you wish to comment.

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