ON TRACK

Strength from Vulnerability

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The *Annals* online discussion since the last issue challenges recent guidelines for hypertension management, informs the use and implementation of electronic health records, draws inspiration from a practice-based research network health behavior change research initiative, and thoughtfully considers the power of sharing vulnerability in clinical practice.

CHALLENGING THE VALUE OF PREHYPERTENSION

The study by Liska and colleagues in the last issue of *Annals*[1] led many to challenge the JNC 7 guidelines,[2] which the study's data were interpreted to support.

Noting that the absolute cardiovascular disease risk for prehypertensive patients is on average quite low, a physician and epidemiologist from the Framingham Heart Study suggest, "Only with global vascular risk assessment is it possible to avoid needlessly alarming or falsely reassuring these prehypertensive patients and subjecting them to therapy they do not need."[3] These writers report the gradual, continuous nature of risk from higher blood pressure, and further note that 80% to 90% of prehypertensive patients in the Framingham Study had at least 1 other cardiovascular risk factor.

A similar finding is reported by Dr William Feeman, a family physician with a 29-year study of atherothrombotic disease in his own practice.[4] Feeman reports a high rate of other risk factors among his patients in the prehypertensive range, and although the Liska et al study adjusted for potential confounders, he hypothesizes that unmeasured confounding may account for the observed risk from prehypertension. Feeman generates a further hypothesis that higher rates of passive tobacco exposure among women may account for a lower predictive value of a model of atherothrombotic disease among women in his practice study.

From the Liska et al study data, another family physician reader estimates prehypertensive patients' unadjusted absolute cardiovascular risk to be about 5% at 17 years. He concludes, "We don't need a new disease, prehypertension, with which to bludgeon our patients into changing their life styles."[5]

A reader from the Center for Medical Consumers[6] raises similar concerns about medicalization of a risk factor that conveys a low absolute risk. She supports the Framingham writers' argument for considering the individual's entire risk profile. She further comments: "Whenever a committee of experts expands the boundaries for who has a disease or condition, I always look for the pharmaceutical industry's influence. It's not hard to find. Strong financial ties to drug companies were found in 9 of the 11 committee members who created prehypertension."

THE ELECTRONIC HEALTH RECORD

Studies from the last issue of *Annals* showed the challenges of implementing an electronic medical record[7] and found a positive effect of an electronic medical record on the process of diabetes care, but not patient outcomes.[8] These studies stimulated a thoughtful sharing of experience and related research on the inevitability and potential of electronic health records, and the need for supportive implementation strategies that are focused on practice transformation.[9-13] Furthermore, several authors call for electronic records that move beyond the physician-centric focus which provokes a cacophony of prompts and reminders. They point to the potential for electronic health records that engage other health care team members and patients in community- and population-oriented systems.[12,14-16] A further challenge is to provide a "computer simulation-based evidence integrator to calculate the most valuable clinical actions for each individual patient."[17] Together, these commentaries call for more sophisticated systems that provide added value to current care and for supportive and realistic implementation approaches.

PRESCRIPTION FOR HEALTH

Prescription for Health is a collaboration of practice-based research networks to generate new knowledge about how primary care practices can promote health behavior change. In discussion of the early findings published in an *Annals* supplement,[18] both systems and frontline perspectives are reflected.

From the front lines, a patient reminds us that a little support at the right time from a primary care practice can make a difference.[19] The lay health coach for one of the projects[20] discovered, when working with more than 100 primary care patients, "a sense of longing, a lack of ful-'fill'ment." She notes that an "[e]mphasis on counting fruits and vegetables, or carbs misses the broader psychological issues. Self-love and its link to self-efficacy may well be underlying attitudes that lead some patients to take action to alter their habits in favor of life and longevity. Having something to move toward and live for may unconsciously impact eating and exercising choices."[21]

Proposed systems solutions from the online discussion include "[a] uniform approach to managing health behaviors, specific diseases and chronic care patients,"[22] and the courage, belief, and vision to move beyond a litany of barriers to make a new model of practice happen.[23]

STRENGTH IN VULNERABILITY

A qualitative research study of doctors exposing their vulnerability[24] and an essay in which a physician shares a patient's story and her own vulnerability[25] unleashed eloquent further reflections. About the qualitative study, Candib notes that "Malterud and Hollnagel teach us to find health in sick people, find strength in doctors' vulnerability, and find objective ways to study doctors' personal experiences." Regarding Shield's essay, she notes that "[r]evealing ourselves to our patients at critical moments can be an act of strength that promotes healing."[26]

Brody,[27] quoting Reich, reminds us that compassion means "to suffer with," and notes that "there can be no compassion without vulnerability." He describes the phases of silent, then expressive compassion, followed by the formation of a new identify in compassion.

Perhaps an increased opportunity for compassion, or at least the ability to abide with patients through both suffering and joy, is the reason that an international study of physicians' valuation of personal continuity of care[28] yielded calls for developing systems to support these ongoing relationships.[29-32] A strong dissenting voice identifies family physicians' advocacy for continuity as a stumbling block to critical evaluation of whether alternatives to personal continuity might have more beneficial effects on patient outcomes.[33]

Swanson was stimulated by Shield's essay to relate her theory of caring[34] and 5 ways of relating that reveal the process of caring: knowing, being with, doing for, enabling, and maintaining belief.

Other writers shared their insights and modeled how sharing vulnerability can be healing.[35,36] Discussants spoke of the connectedness of all mothers,[37] the power of birth, and the trauma of the loss of human possibility.[38]

A discussant of the qualitative study of frequent attenders in the last issue[39] points out that many frequent attenders ("heartsink patients") "present with somatic complaints to the GPs, returning again and again because they underlying issues are not addressed."[40] Foreshadowing the message of the essay by Tarn in this issue,[41] she notes how important the handling of these underlying issues is in helping patients to listen to the messages carried by their bodies and in fostering healing.

Interestingly, Candib's essay "Making Time to Write"[42] elicited calls to use writing as a way to witness, reflect, integrate, consolidate relationships,[43,44] and exchange ideas.[45] Others took inspiration for their own writing[46,47] and called for a forum for "giving voice to our personal experiences as physicians."[48] These reflections on writing are relevant here because even though only "[t]he most talented writers among us will get some of those writings published,… all of us will benefit from reflecting on what we do, and from the healing that comes in the creation of stories"[44]—a parallel process for what shared stories can do for our patients.

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