ON TRACK

Practical and Contextual Issues

Kurt C. Stange, MD, PhD, Editor

Ann Fam Med 2005;3:556-558. DOI: 10.1370/afm.416.

The *Annals* online discussion has brought out practical and contextual concerns about articles in the last issue.

PRACTICAL ISSUES

The cost-effective analysis of expanded testing for primary HIV infection generated a call for consideration of practical issues.[1,2] The time needed to discuss HIV testing during "the frequent (and often pleasingly quick) viral illness visit,"[3] could result in difficult trade-offs for the physician's workday. Focusing on identification of patients with at least one specific behavior that constitutes a risk factor may be a partial solution.[4]

This discussion points out the need to consider the effect of new interventions on the totality of care provided. This includes the trade-offs in which additional interventions may bump other aspects of care off the agenda of patient visits, how the growing agenda for those receiving care may affect access to care for others with less entrée, and how the growing number of options for care affects the providers of care. Indeed, Sykes[4] reminds us "that, in this time of limited resources, it is not enough to determine if a program or policy is cost-effective according to some arbitrary standard. To utilize limited resources effectively, what we must ask is, which policy is MOST cost effective?"

JOURNAL CLUB

The value of a good estimate of the prevalence of primary HIV infection in symptomatic outpatients was appreciated by Buzanowska and colleagues,[5] who raise a number of concerns about implementing testing for primary HIV infection in low-risk general population settings. What is remarkable about this thoughtful commentary is that it comes from a student-run journal club. The editors applaud the initiative of these students in carefully reviewing a research article and in submitting their commentary to the online discussion. We invite other student and resident journal clubs and other groups to discuss *Annals* articles and to share the results of their discussions.

THE IMPORTANCE OF THE SYSTEMS AND CULTURAL CONTEXT

Prunuske[6] highlights the need for reimbursement system changes if the benefits of patient-centered communication found by Epstein et al[7] are to be feasible.

The article by Crabtree et al[8] generated dissent over its "overly pessimistic"[9] interpretation of the challenges of improving prevention in practice.[10] Discussants identify the need for office systems to support prevention[9,11,12] and the important effects of the larger health care system context.[13]

Richardson[14] and Bope[15] hope that information from an international comparison of treatment of pneumonia in nursing home residents[16] may guide reconsideration of the currently more aggressive treatment in the United States.

Rose[17] believes that the "paper by Walter and Emery[18] is novel because it tackles these issues (genetic risk and patient understanding) together and within a primary care population.... (I)n the consulting room the medical and sociological aspects present together and are often indecipherably intertwined."

Regarding obesity treatment, Scott[19] identifies "the root causes of the US obesity epidemic. Those causes are societal and structural and require policy and legislative solutions. We will be doing a disservice to our patients if we focus only on treating individual obese patients and fail to use our medical knowledge to promote intelligent design of our work places and our communities, as well as some reasonable regulation of the food industry."

CHOOSING PATIENTS FOR TREATMENT

A meta-analysis in the last issue of the *Annals* showed the effectiveness of antidepressant medication in primary care patients.[20] Two discussants point out the modest treatment effect (slightly more than one half of patients respond).[21-23] They raise questions about which patients respond, how this can be predicted and augmented, and how systems can be designed to facilitate care in practice.

Regarding the systematic review that found no effect of metformin for treatment of obesity,[24] Woliner presents a rationale for identifying a subgroup of insulin-resistant patients, and raises the hypothesis that they may benefit from metformin.[25]

SURVIVORS OF CHILDHOOD SEXUAL ABUSE

Readers informed by experience called for clinicians to ask about childhood abuse in sensitive ways[26-28] by asking "How has abuse affected your life?" rather than "Have you ever been abused?" The danger of re-traumatizing[27] highlights the need for sensitivity. The presence of a number of chronic conditions and a mismatch between affect and situations may serve as red flags to identify potential abuse survivors.[28,29]

THE GOOD AND BAD OF CONTINUITY

Readers from multiple countries continue to resonate with the international survey of the importance of continuity of care to family physicians.[30-34]

Another physician,[35] prompted by Dr. Neher's essay in the last issue of the *Annals*,[36] was highly critical of the effect of his strong doctor-patient relationship on possibly delaying the revelation of the past abuse of one of his patients. Although this delay was found to be not unusual by a family therapist discussant,[28] this physician notes that "sometimes the relationship itself can be a barrier."

Please join 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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CORRECTION

An error has been reported in the article by James E. Aikens, PhD, Donald E. Nease, Jr, MD, David P. Nau,PhD, Michael S. Klinkman,MD, MS, and Thomas L. Schwenk, MD. Adherence to maintenance-phase antidepressant medication as a function of patient beliefs about medication. *Ann Fam Med.* 2005;3:23-30.

In the "Results" subsection "Validity and Confound Checks" (page 26), the following sentence erroneously contained the 2 variables "medication beliefs" and "adherence."

"Student *t* tests and χ^2 analyses, however, showed no significant differences in medication adherence between groups based on depression severity, medication beliefs, adherence, medical comorbidity, age, or sex; nor did adherence differ significantly by whether a patient saw a mental health professional."

The correct version of this statement should read: "Student *t* tests and χ^2 analyses, however, showed no significant differences in medication adherence between groups based on depression severity, medical comorbidity, age, or sex; nor did adherence differ significantly by whether a patient saw a mental health professional."

The author regrets the error.