On TRACK: Challenges and Insights

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In the recent TRACK discussion of articles, readers provided new information, challenged our ways of thinking, and reflected on where family medicine has been and is going.

INSIGHTS

Clinicians 'don't want to ask about things for which they don't have good solutions or resources that work'

The above quotation[1] encapsulates a rich discussion of the challenges of elder abuse reporting, which were reported in the September/October issue of *Annals*.[2] This quotation also provides a litmus test that should be applied before recommending additional screening or surveillance amidst the already-full primary care agenda.

Night Sweats—A Complicated Differential Diagnosis

An interesting interaction between a study author[3] and several discussants sheds light on patients complaints about night sweats[4-10] as a marker for obstructive sleep apnea.This discussion exemplifies what can happen when an investigator, a practice-based research network, and collaborators with specialized expertise come together to ask what starts as a simple question, but turns out to be complex and fascinating. A line of inquiry into deeper basic and clinically applicable understanding is starting to emerge here.

Handout to Foster Informed Decision Making About Prostate Cancer Screening

In response to a recent article on discussing PSA tests,[11] Hahn[12] offers a handout to foster shared decision making about prostate cancer screening. The handout conveys relevant information and perspective, and looks like it might be a useful way to jumpstart shared decision making about PSA testing: https://mywebspace.wisc.edu/xythoswfs/webui/_xy-8053927_1-t_xereO7mQ .

CHALLENGES

Several comments challenged the validity of research or the interpretation of research published in the last issue of *Annals*.

The article by Meurer et al[13] led to several calls to remain focused on developing systems to reduce medical errors, even as we work to better characterize them. Bates further notes that numbers based on claims data "must be interpreted with considerable humility."[14] Bates also suggests that comorbidity likely is an effect modifier as well as a confounder, and that adjusting for the confounding effects does not solve the problem of characterizing the relationship between adverse events and mortality.

Amidst an active discussion which appears to validate with experience the findings of a study[15] showing that patients' insurance status alters clinical care by physicians, Pontious[16] notes that conducting the study in community health centers may engender selection bias. He advises caution in transporting the findings to other practice settings.

Rimm[17] challenges the interpretation of the McFall study[11] of communication between doctor and patient about the advantages and disadvantages of PSA testing. Rimm notes that the data used for the study do not address the problem of what percentage of patients know about the PSA test when they have the test. He concludes that the 63% of tested men who reported having discussed the advantages and disadvantages about their most recent PSA test may be a considerable understatement of the patient's actual knowledge of the test.

Finally, the philosophical discussions cited below challenge not only the focus of family medicine, but how we know what we know.

Identity and Philosophical Underpinnings

Family physicians are a practical lot, focused on what works. To frame, focus, and funnel this pragmatism, it is helpful to step back every now and then to look at the ways of knowing that support our work. I'd recommend 2 online discussions that are helping to create a com-

munity of learning about our philosophical roots. These discussions can be found online through the articles that stimulated them: the personal and practical application of epistemology and ontology by Thomas,[18] and the treatise by Stein on family medicine's identity.[19]

FAMILY MEDICINE DEPARTMENTS AND THE FUTURE OF ACADEMIC HEALTH CENTERS

The *Annals* supplement on the future of academic health centers (AHCs) stimulated testimony from many family medicine department chairs and other leaders in academic family medicine. These observations range from hope, to reflections on the need for dramatic change, to skepticism about the ability of AHCs to foment such transformation.

A few quotations can help to characterize this discussion:

"Having practiced before and after the introduction of socialised medicine to Canada, and practicing at that time exclusively with the underprivileged, I can testify to the fact that overnight people became equal in their access to medical care. That did not come about through efforts of Academic Health Centers but through the decision of the Canadian people and their governments to create a system which permitted equality."[20]

"Many of our universities developed primary care clinical networks during the era of managed care. In some cases, these networks were created to serve community needs, but most of them were created to insure an uninterrupted flow of referrals and admissions to the university hospital … we are focusing much more on making patients happy and serving their needs better rather than simply making health plans happy and seeking favorable contracts."[21]

"[We] are competing for a small percentage of commercially insured patients to achieve a modest positive margin, so we can stay afloat and keep our eye on our real mission which is to serve the poor people of Texas. It is getting harder and harder to do this."[22]

"Justification for increasing the number of medical students based on community needs[23] and 'social accountability'[24] is a refreshing departure to current exhortations to expand physician supply based on increasing consumer demand.[25]

"Documenting need for more physicians is not easy. Evidence suggests that ageing of the population is NOT a main contributor to increasing need.[26] The increased prevalence of diagnosed ill health, the particular interests of different types of physicians and their distribution in the population, and standards of practice are, in contrast, changing the playing field.

"Artificially created 'need' is rampant. Rates of increase in frequency of almost all diagnoses have been documented.[26] Changing thresholds for diagnosis of diseases are widespread, and new diseases (such as 'restless foot syndrome') are appearing as a result of a pharmaceutical industry interest in developing new markets for its products.[27] Changing standards of care resulting from implementation of guidelines is putting increased pressure on practitioners, especially primary care practitioners, even though not all recommended interventions are warranted or of high priority.[28] Justification for training more specialists is contradicted by evidence that an increasing supply and use of specialists often results either in no added benefit or worse outcomes.[29] Thus, following the call for more physicians, under circumstances in which most will become specialists, is not a benign strategy. Following the dictum that the number of physicians should follow from the health needs of populations and be pursuant to 'social accountability,' the major challenge is to make training more congruent with these principles.

"Most changes in health needs are for outpatient services, not inpatient services. The dangers of hospital-based training for physicians who will end up in community practices are documented both theoretically and empirically.[29] Now more than ever, we need a concerted effort to document how hospital-based and community-based physicians could better work together to define their relative roles and their interrelationships in the care of patients and populations. There is much that can and should be done to make specialists better serve the needs of both patients and primary care physicians in the interests of avoiding unnecessary care and the adverse events that follow from them. Evidence-based advocacy for greater effectiveness and greater equity can be found only in the case of increasing the supply of primary care physicians. Arguments for increasing the overall production of physicians, most of whom will end up in specialty practice, is not based on evidence of need, at least not in the United States. Uncritical movement in this direction is at the peril of population health and social accountability."[30]

References

1. Zink TM. Realities of reporting abuse [eletter]. http://www.annfammed.org/cgi/eletters/4/5/403#4423, 1 October 2006.
2. Rodriguez MA, Wallace S, Woolf N, Mangione C. Mandatory reporting of elder abuse: between a rock and a hard place. *Ann Fam Med.* 2006;4:403-409.
3. Mold JW, Wooley J, Nagykaldi Z. Associations between night sweats and other sleep disturbances: an OKPRN study. *Ann Fam Med.* 2006;4:423-426.
4. Noon S. Associations between night sweats and other sleep disturbances [eletter]. http://www.annfammed.org/cgi/eletters/4/5/423#4401, 30 September 2006.

5. Mold JW. Response [eletter]. http://www.annfammed.org/cgi/eletters/4/5/423#4460, 2 October 2006.

6. Viera AJ. Toward an evidence-based differential diagnosis of night sweats [eletter]. http://www.annfammed.org/cgi/eletters/4/5/423#4499, 6 October 2006.

7. Mold JW. Night sweats and sleep disturbances [eletter]. http://www.annfammed.org/cgi/eletters/4/5/423#4506, 8 October 2006.

8. Duhon DR. Night sweats and obstructive sleep apnea\hypopnea syndrome [eletter]. http://www.annfammed.org/cgi/eletters/4/5/423#4538, 12 October 2006.

9. Mold JW. Night sweats and obstructive sleep apnea [eletter]. http://www.annfammed.org/cgi/eletters/4/5/423#4543, 13 October 2006.

10. Henderson L. Journal club USA family medicine [eletter]. http://www.annfammed.org/cgi/eletters/4/5/423#4600, 27 October 2006.

11. McFall SL. Discussing prostate-specific antigen tests with a physician by US men. *Ann Fam Med.* 2006;4:433-436.

12. Hahn DS. PSA patient information: be mindful how you use it [eletter]. http://www.annfammed.org/cgi/eletters/4/5/433#4449, 3 October 2006.

13. Meurer LN, Yang H, Guse C, Russo C, Brasel K. Excess mortality due to medical injury. *Ann Fam Med.* 2006;4:410-416.

14. Bates DW. What's the real number? Excess mortality and medical injury [eletter]. http://www.annfammed.org/cgi/eletters/4/5/410#4476, 6 October 2006.

15. Meyers DS, Mishori R, McCann J, Delgado J, O'Malley A, Fryer E. Primary care physicians' perceptions of the effect of insurance status on clinical decision making. *Ann Fam Med.* 2006;4:399-402.

16. Pontious JM. Exposing the crazy aunt in the attic [eletter]. http://www.annfammed.org/cgi/eletters/4/5/399#4404, 29 September 2006.

17. Rimm AA. Absence of discussion between physician and patient about PSA test does not mean patient does not know the advantages and disadvantages of the test [eletter]. http://www.annfammed.org/cgi/eletters/4/5/463#4417, 1 October 2006.

18. Thomas P. General medicine practitioners need to be aware of the theories on which our work depends. *Ann Fam Med.* 2006;4:450-454.

19. Stein HF. Family medicine's identity: being generalists in a specialist culture? *Ann Fam Med.* 2006;4:455-459.

20. Lehman FE. Is it realistic in the USA [eletter]? http://www.annfammed.org/cgi/eletters/4/suppl_1/S2#4462, 3 October 2006.

21. Saultz JW. Primary care networks [eletter]. http://www.annfammed.org/cgi/eletters/4/suppl_1/S12#4478, 6 October 2006.

22. Thompson BL. Lessons learned [eletter]. http://www.annfammed.org/cgi/eletters/4/suppl_1/S12#4414, 29 September 2006.

23. Berg AO, Norris TE. A workforce analysis informing medical school expansion, admissions, support for primary care, curriculum, and research. *Ann Fam Med.* 2006;4(Suppl 1):S40-S44.

24. Rourke J. Social accountability in theory and practice. *Ann Fam Med.* 2006;4(Suppl 1):S45-S48.

25. Cooper RA, Getzen TE, McKee HJ, Laud P. Economic and demographic trends signal an impending physician shortage. *Health Aff (Millwood).* 2002;21:140-154.

26. Thorpe KE, Florence CS, Howard DH, Joski P. The rising prevalence of treated disease: effects on private health insurance spending. *Health Aff (Millwood).* 2005;W5:317-325. Available at: http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.317v1.

27. Dyer O. GSK breached marketing code. *BMJ.* 2006;333:368.

28. Coffield AB, Maciosek MV, McGinnis JM et al. Priorities among recommended clinical preventive services. *Am J Prev Med.* 2001; 21:1- 9.

29. Starfield B, Shi L, Grover A, Macinko J. The effects of specialist supply on populations' health: assessing the evidence. *Health Aff (Millwood).* 2005;W5:97-107. Available at: http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.97v1.

30. Starfield B. Health needs, demands, and workforce issues [eletter]. http://www.annfammed.org/cgi/eletters/4/suppl_1/S40#4483, 6 October 2006.

CORRECTION

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Alfred O. Berg and Thomas E. Norris: A workforce analysis informing medical school expansion, admissions, support for primary care, curriculum, and research. *Ann Fam Med.* 2006;4(Suppl 1):S40-S44.

This case study by Berg and Norris was given an incorrect digital object identifier (DOI) number in the print version of "Shaping the Future of Academic Health Centers," a journal supplement published with the September/October issue of the *Annals.* The print version of the article therefore departs from the online version. The correct number is DOI: 10.1370/afm.523.