Hypotheses and Questions

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Hypotheses and questions jump out of the TRACK online discussion. Using the articles in the last issue as a catalyst, readers propose ideas for next steps to be tested in research and practice. Here is a sample.

The study showing huge variability in evidence-based guidelines for diagnosis and treatment of pharyngitis[1] created a buzz of testable theories and questions:

[Does] following guidelines lead to better patient outcomes?[2]

The truth about guidelines is that they are molded through the value structure of the panel members.… Unless we can agree on values, we cannot achieve consensus on guidelines.[3]

[N]o matter how "evidence-based" a guideline may appear, unless it has been validated by at least one practice-based effectiveness trial in a relevant population, the guideline must still be considered as an hypothesis to be tested.[4]

[T]he essence of evidence-based practice is empiricism. If we are burdened with too much pathophysiology (understanding of the mechanism of disease) we are likely to allow our prejudices to warp our objectivity.[5]

What we need is help in the difficult steps of evidence-based medicine, not just a pre-digested sop to eat in its stead.[5]

The study of improving communication between doctors and breast cancer patients[6] yielded a partial research agenda for the field:

The need to try to regain control ought not to be minimized by professionals ... non-verbal communication … deserves to be the focus of a long-term and well-orchestrated research program.[7]

[T]here is a clear dose-response relationship with communication skills training.[8]

Internet access to public information has expanded the role of the physician.[9]

Educational interventions will likely need to be tailored to specific types of learners if they are to have their intended impact.[9]

Specifically tailored education is needed for each specialty.[10]

The timing of when bad news is communicated to a cancer patient … may influence how much she retains, what her perception is of the news (prognosis) and how she will approach decision making about treatment.[10] [Editor's note: see this TRACK comment (http://www.AnnFamMed.org/cgi/eletters/5/5/387#6464) for a marvelous example of how bad news can be shared in a hopeful and hope-inducing way.]

Other articles yielded interesting hypotheses as well:

The gender differences in these findings (the association of anger with progression of hypertension to hypertension)[11] are somewhat striking and deserve greater attention.[12]

[A]nger has a stronger association with cardiovascular risk among men than women, while other psychosocial factors have more similar effects.[12]

[I]f their doctors had just asked about a mental health problem, many [suicide survivors] would not have made their attempt.… [S]howing care, concern, and understanding that mental pain and anguish can be just as painful as the worst cluster migraine or kidney stone is generally enough to start a conversation.[13]

[W]ith the right information, resources and time, physicians can play a critical role in preventing suicide and the tragic consequences it has on those left behind.[13]

[T]he "market" in the US has already communicated their satisfaction with urgent care centers as a provider of acute care services.[14]

[I]t would be interesting to look at large and small urban areas, as well as rural and remote areas to get a sense of patient satisfaction and the different issues that exist in diverse geographic settings.[15]

If the family physician is supported by specialists and proper funding in order to extend clinic hours to meet the access and availability issues, they can in turn reduce the burden of current levels of emergency room activity by managing patients in the community, and therefore relieving emergency room personnel to focus on critical and urgent problems.[15]

How long did physicians spend with patients discussing domestic violence screening across methods … and what are the costs?... How do the costs of screening/training/

monitoring compare to cost savings from adverse outcomes and excess care?[16]

For the effectiveness of antihypertensive therapy:

The data are less robust for Asians and there are almost no data for Native Americans.[17]

The "teamlet" approach[18]... appropriately assigns important parts of the visit, such as information intake, medication reconciliation, standing orders for diagnostic management, and patient coaching, to the non-physician staff. With these things done and documented, the physicians can concentrate on further high level assessment, asking clarifying questions and building a relationship with each patient. Just as important, the post-visit is critical, and something that is not being done in today's office exams.[19]

An action plan may yield better outcomes when coupled with health coaching strategies to assist patients in changing health behaviors.[20]

Please join the exchange of questions, hypotheses, and ideas at http://www.AnnFamMed.org, and consider testing a few of the hypotheses and questions raised by other *Annals* readers.

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