ON TRACK

Healing Perceptions and Relationships

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The recent online discussion of *Annals* articles brings together perspectives from around the world. The dialogue includes experts, authors, and people whose authority comes from their on-the-ground perspective. Below are 3 themes that emerged on healing, the potential for patients' and clinicians' understanding to alter the course of illness and health, and the role of the family physician in the hospital.

INTEGRATION AND HEALING

The discussion around several articles in the last issue raises a 2-tailed hypothesis: that healing is diminished by fragmentation of perception and relationships, and that it is fostered by integration of vision and connections.

Frey hypothesizes that a major benefit of a statewide network to improve the quality of care may be in getting "sometime rivals in communities to talk with each other, find common ground, bring resources that can be used by the networks and the individual practices to meet patient needs."[1]

Freedy summarizes his main points about the Bogner study of integrated care of hypertension and depression[2,3]:

> (1) Power in primary care means the ability to reliably reduce morbidity and mortality. (2) Chronic depression and anxiety (often found in primary care patients) are consistently associated with factors (eg, chronic disease, smoking, alcohol abuse, etc.) that adversely impact morbidity and mortality. (3) The magic in primary care lies in understanding that by addressing chronic mental health issues, we may change factors that adversely impact morbidity and mortality (and thus improve the patient outcomes that we care most about).

Qidwai raises concern about the loss of holistic and relationship-centered perspectives[4]:

> Modern day medical practice is losing personal touch, becoming more technical, investigation oriented and defensive. The focus is not on a person as a whole, but rather on a system or an organ supposedly at fault that requires fixing. The disintegration of medical practice today with less focus on holistic approach is resulting in loss of healing properties inherit in the consultation process.

Scott notes the emergence of a common definition of healing among 3 studies of healing in the last issue.[5-7] These 3 studies independently identified relationships as an essential component of healing.[8] This theme is echoed below by those commenting on the study by Gramling et al in the same issue.[9]

PATIENTS' AND CLINICIANS' UNDERSTANDING

The study by Gramling et al of the association between self-rated cardiovascular risk and 15-year cardiovascular mortality[9] stimulated the hypothesis "that some degree of unrealistic optimism is healthy."[10] Epstein's commentary stands as a clinically useful synopsis of the field and portrayal of researchable hypotheses.[10] Fiscella notes that "people have an intuitive sense of their health beyond that captured by standard medical measures."[11] He hypothesizes that "self-rated risk represents the flip side of self-rated health," which has been highly predictive of longevity and health. Getz explains the importance of confronting the patient's perception of risk with care, since "even the most benevolent medical act may carry with it a risk of subtle harm."[12]

The importance of patients' and clinicians' understanding are further highlighted by the discussion of the study by Chew-Graham et al of patients with chronic fatigue syndrome.[13] May highlights "the mechanisms by which diagnostic naming is negotiated. … The giving of names to human experiences is of more than technical importance in medicine, but has important ritual meanings for participants."[14] White and van der Meer and Bleijenberg also point out valuable resources for both clinicians and patients to learn about chronic fatigue syndrome.[15,16]

THE ROLE OF THE FAMILY PHYSICIAN IN THE HOSPITAL

Glazner's essay on the role of the family physician in the hospital hit a nerve with many readers.[17]

Phillips contends "there should be no question that family physicians have the capability to diagnose and

treat—not just recognize and refer—serious illness when it occurs in their patients."[18]

Gillanders argues that reduced presence in the hospital "is something we have done to ourselves in the name of more efficient use of fixed office overhead, better ambulatory access in the face of 'primary care shortage', and, of course, 'lifestyle'."[19]

Tiemstra notes[20]:

> Dr. Glazner's article illustrates 3 important roles for the family physician in the hospital: (1) the manager of multiple medical problems for a complex patient with a straightforward problem; (2) the patient advocate/ethics consultant for a patient who's values don't correlate with the consultants' values, or are just not understood and explored by the consultant; and (3) the coordinator of inpatient care with outpatient care. When a family physician is lacking, these roles still need to be filled, so the patient gets a hospitalist, an ethicist, an ethics committee, and a discharge planner; all strangers to the patient, none seeing the whole picture, and none responsible to the patient for the whole picture. What patient would not prefer a family physician if the choice were available to all?

Reidy suggests that seeing hospitalized patients and billing (as a consultant when the visit was requested, using a subsequent visit code when it was not) is a way to overcome lack of communication with hospitalists.[21]

Centor observes that "family physicians have the advantage of continuity of context.… Too often patients have multiple soloists treating them, each with their own hammers looking only for their own nails. Patients need conductors for the subspecialty symphony."[22]

An associate residency director who recently started a hospitalist fellowship notes that "My gen x and y learners teach me that having a lifestyle and a profession are not mutually exclusive, and that family physicians can be hospitalists, or 'ambulists', or full scope, as they see fit."[23]

Siegel doubts that it is essential to have primary care physicians work in the hospital, noting that family physicians in a number of other countries have never worked in hospitals.[24]

Echoing the theme from the comments about the healing studies, Tumerman asks, "How many different ways do we need to say, that it is all about the relationships we have with our patients that defines who we are and why family physicians are so important to the health care system?"[25]

In response, the author notes:

> I cannot reconcile family physicians arguing that the specialty provides continuity of care across the health care spectrum, while at the same time consciously and purposefully pulling out of hospital care. Hospitalization is a time when our patients are in greatest need of their primary care physician. How can our specialty argue that we are central to a healthy, functional health care system of the future when we are present for our patients at our convenience, and not their need? We cannot.
>
> This is a critical time for family medicine; the current non-system of health care is crumbling and the future is a mystery. Family physicians must continue to be present and necessary in order to influence that change and be at the core of a future health care system. We have tremendous power as family physicians, but I see a tremendous reluctance to exercise that power.
>
> Giving up is not the answer. Working harder in the old paradigm is not the answer. Training residents to do less is definitely not the answer. The Gen X and Y graduates will be able to adapt systems in ways that we cannot, so it seems even more important they be trained with all the belief and skills that we were by our predecessors.
>
> Dare I say that it is a matter of keeping the faith? If we lose our belief that what we do is meaningful, important and of unmeasurable value, then we have lost already and will become extinct, a footnote in a medical history book. If we maintain our belief that what we do as family physicians is the heart and soul of medicine, we survive and thrive during difficult times of change. Patients benefit; residents benefit; physicians benefit.
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> It is our choice. May we choose wisely.[26]

Please add your voice to this evolving community of knowledge by joining the discussion at http://www.AnnFamMed.org.

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CORRECTIONS

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A typographic error occurred on the last line of Table 1, column 2. The LDL control <100 mg/dL for CCNC patients should be 56% rather than 5%. A corrected Table 1 is shown:

In the same article, the authors wish to acknowledge the contributions of the leadership and practicing physicians who have made Community Care of North Carolina a reality over the last decade, as well as the North Carolina Foundation for Advanced Health Programs for its support of Community Care of North Carolina.

Table 1. 2006 Community Care of North Carolina Diabetes Audit (n = 9,012)

Measure	NCQA[a] Threshold %	CCNC Patients %
HbA_{1c} control <7.0%	40	47[b]
HbA_{1c} control >9.0%	≤15	21
Blood pressure control ≥140/90 mm Hg (SBP ≥140 or DBP ≥90)	≤35	34[b]
Blood pressure control <130/80 mm Hg (SBP <130 and DBP <80)	25	37[b]
LDL control ≥130 mg/dL	≤37	19[b]
LDL control <100 mg/dL	36	56[b]

CCNC = Community Care of North Carolina; DBP = diastolic blood pressure; DPRP = Diabetes Physician Recognition Program; HbA_{1c} = glycated hemoglobin; LDL = low-density lipoprotein cholesterol; NCQA = National Committee for Quality Assurance; SBP = systolic blood pressure.

a Threshold from NCQA DPRP 2006 used for comparison purposes only.

b Meets threshold.