

The Complexity of and Opportunity for Screening in Primary Care

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Ann Fam Med 2009;7:2-3. DOI: 10.1370/afm.960

This issue features articles on the early detection of disease and risk factors.

Four of these articles¹⁻⁴ and an editorial⁵ showcase colorectal cancer screening. Three of these studies evaluate the role of primary care in colorectal cancer early detection. A study using nationally representative data¹ shows that colorectal cancer screening rates are associated with having a personal clinician, as well as with social factors. In contrast, Jimbo and colleagues² find that primary care physician decisions are a major factor in patients not undergoing complete evaluation for a positive fecal occult blood screening test. To further complicate the picture of the role of primary care physicians in colorectal cancer screening, Wilkins conducts a meta-analysis of 12 studies of colonoscopy by primary care physicians, finding quality parameters similar to those in studies of specialists.⁴

The fourth colorectal cancer screening study, featured as this issue's *Annals* Journal Club selection, is a clinical trial of a pragmatic intervention that links fecal occult blood testing to influenza immunization clinics. The dramatic effect shows that, when properly configured, complementary services can represent competing opportunities⁶ rather than competing demands.⁷

Several other studies in this issue address screening for other conditions. Jeppesen and colleagues find complementary value in several different brief screens for health literacy.⁸ Gjerdingen et al⁹ find that the optimal strategy for identifying women with postpartum depression may be a 2-stage screening procedure that involves using a 2-item initial screen, followed by a 9-item instrument for those whose screening test was positive. Rhodes et al,¹⁰ screening for intimate partner violence among men seen in an urban emergency department, find the highest rate of mental health symptoms occur among men who disclose both victimization and perpetration. This finding shows that the simplistic label of victim or perpetrator masks a more complex problem. A clinical policy guideline based on a systematic review¹¹ finds strong evidence for screen-

ing patients for depression after myocardial infarction and moderate to strong evidence for treatment.

A population-based study of children with asthma finds greater prescribing variability in younger children.¹²

Patient requests for specific new prescriptions are found in 3.5% of patient visits to clinicians in a practice-based research network.¹³ Although physicians reported that the requested medication was not their first choice for treatment, in 62% of these instances, the medication was prescribed 53% of the times it was requested. Despite this finding, clinicians reported a negative impact from these requests, stimulated by direct-to-consumer advertising, in only 10% of visits.

An essay by Buetow uses the art concept of negative space to help us see patients and situations (and sometimes ourselves) in relief, separated from preconception and focused on the moment.¹⁴

Please share your insights on these articles and your experience with the important topics they bring up by joining the *Annals* online discussion at <http://www.AnnFamMed.org>.

To read or post commentaries in response to this article, see it online at <http://www.annfammed.org/cgi/content/full/7/1/2>.

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EDITORIAL

The Aftermath of Efficacy

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Ann Fam Med 2009;7:3-4. DOI: 10.1370/afm.959

As a member of the US Preventive Services Task Force for 12 years and its chair for 5, I have given countless presentations on Task Force recommendations. During questions and comments, clinicians often voice frustration and even hostility to the recommendations because the Task Force does not advise on exactly what should happen next. My response is that, indeed, the science is the easy part and that effective implementation is hard, particularly in a health care environment that discourages system innovation. Although the process of sifting through the medical literature to determine the quality of evidence that supports (or fails to support) a preventive intervention is time consuming, costly, and, at times, tedious, it is not particularly complicated. If the Task Force has set up the analytic framework correctly, identified the key questions, and carefully followed protocol in completing the evidence review, the conclusions usually follow easily. Screening for colorectal cancer is a good exam-

ple of where the science showing efficacy of screening is fairly straightforward, but where the paths to effective implementation are not. In its updated recommendation released in October, 2008,¹ the Task Force has judged that screening works, but then what?

Four articles in the current issue of the *Annals of Family Medicine* address "then what" in different ways. Potter and colleagues show that offering fecal occult blood kits to patients during flu shot clinics increased screening from 57% to 84%.² Using data from the Behavioral Risk Factors Surveillance System, Cardarelli and Thomas show that having a personal health care provider is associated with a 3-times higher likelihood of screening.³ Jimbo and colleagues examined reasons that positive fecal occult blood tests were not followed up, finding that such decisions were at variance from established guidelines or could not be determined in nearly one-half.⁴ Finally, Wilkins' group conducted a quantitative meta-analysis of the literature on the outcomes of screening colonoscopies performed by primary care physicians, showing that quality, safety, and efficacy are similar to indicators proposed by specialty professional groups.⁵ These new articles are high-quality work, showing imagination and skill on the part of the investigators. My comments briefly address the audiences of physicians, patients, and policy makers.

Physicians eager to implement prevention in practice have long recognized the importance of an established relationship and of using every opportu-

Conflict of interest: none reported

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